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JANUARY, 1974
VOLUME 71, NUMBER 1

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Ellis Fischel State Cancer Hospital and Cancer Research Center
SPECIAL ISSUE

This psychoneuroti often respond

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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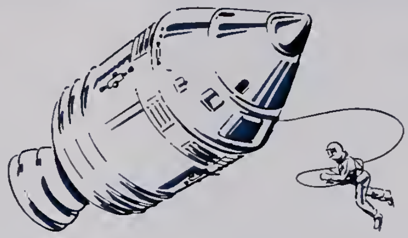

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AN IMPORTANT NOTE:
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CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
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Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic endproducts do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease: history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
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MSMA NEWS ROUND-UP

JANUARY, 1974

Missouri carved into 5 PSRO's

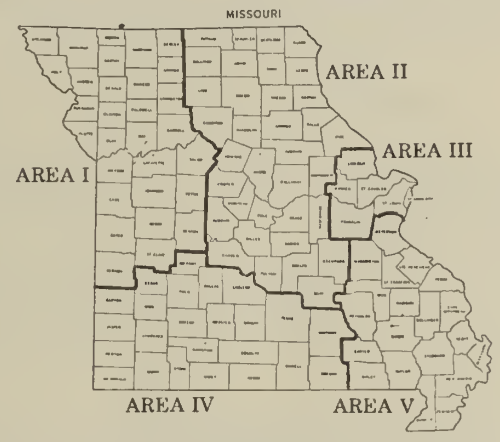
Five Professional Standards Review Organizations (PSROs) would be established in Missouri under a Department of Health, Education and Welfare proposal due to become effective Jan. 20.

The designated areas conform exactly with those proposed in August by the Health Care Foundation of Missouri and representatives of each of the present HCFM Regions (see map). These areas were supported by the Missouri State Medical Association and most other medically-related groups in the state.

Figures from the 1971 edition of "Physician Manpower in Missouri" show that the approximate physician population in the five PSRO areas range from 2,974 in Area III to 339 in Area V. Area I has 1,698 physicians, Area II has 872 physicians and Area IV has 551 physicians.

The Missouri PSRO areas were part of a total of 182 PSROs designated nationally.

Following the 30-day period for public comments, suggestions and objections, the Department of HEW will enter into agreements with organizations in each area to review care of patients under the federal Medicare, Medicaid and Maternal and Child Health programs.



According to HEW, standards under which the PSROs will operate will be set by the participating physicians, not the federal government.

AMA stand on PSRO.....from repeal to leadership

After long hours of hearings and floor debate, the AMA House of Delegates adopted the following position on PSROs at the Clinical Session in early December.

The AMA affirms the following principles:

1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and
2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and
3. That the Association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and
4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public.

The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our long-standing policy and opposition to this legislation prior to passage.

The considered opinion of the Board of Trustees and the Council on Medical Service is to recommend to the House of Delegates that the AMA continue to exert its leadership and support constructive amendments to the PSRO law, coupled with continuation of the effort to develop appropriate rules and regulations.

New services proposed

Council views budget deficit, dues

A budget deficit, a proposal to increase MSMA dues and PSRO were the major topics at a busy December meeting of the MSMA Council.

A budget of $366,906 was approved for 1974. This represents less than a 4% increase over the 1973 budget, but decreasing income from advertising in MISSOURI MEDICINE and interest on bonds sold earlier to finance the new Headquarters resulted in a deficit of $11,231. The Missouri State Medical Foundation (student loan program) will be asked to pay for the staff services which the MSMA has provided in the past. This would reduce the deficit to $4,631.

Inflationary demands caused most of the budget increase with Annual Session costs estimated at 16% higher and salaries about 5.5% higher.

Proposed Dues Increase

A comprehensive report from the Planning Committee, which includes a proposed dues increase, was adopted and will be presented to the House of Delegates.

The proposal recommends raising MSMA dues to $90 plus the current $10 assessment for the student loan program. Missouri's current $65 dues are the lowest in the nation except for Virginia. Over half the states have dues ranging from $120 to $450.

Along with the dues increase, the additional following services were proposed:

* Two new field secretaries would be hired. They would personally contact each MSMA member at least twice annually to keep members better informed on major issues and on MSMA services.

* Funds would be made available to Councilors to maintain direct contact with members in their districts.

* The proposed Continuing Medical Education program for the MSMA would be financed with the added funds.

* The MSMA would expand its services in such areas as auto leasing, expanded insurance programs, etc.

Endorse PSRO Stand

Concerning PSRO, the Council endorsed the recent stand taken by the AMA (found on preceeding Page) after deleting the sections relating to "non-participation."

The AMA recently inquired whether the MSMA would actively seek repeal of PSRO and the Council passed the following motion:

"The MSMA Council believes that the PSRO law should be repealed or effectively amended and we will work actively with the Missouri Congressional Delegation to this end."

In other actions, the Council:

— Accepted a report from the Commission on Medical-Legal Affairs which recommended the evaluation of the malpractice situation in Missouri with the aim of determining a solution and the feasibility of a group professional liability insurance program for the MSMA.

Accept Nurse Guidelines

— Accepted guidelines relating to emergency lifesaving services which are sometimes required of a nurse when a physician is not present, as presented by the Commission on Continuing Education and Health Manpower. The guidelines concern intracardiac drugs and endotracheal intubation. They will be published in full in the February MISSOURI MEDICINE.

— Heard a detailed report on the AMA meeting and the AMA's stand on PSRO.

— Accepted the report of the Commission on Constitution and Bylaws as published in this edition.

— Accepted with commendation the report of the Ad Hoc Committee on Continuing Medical Education which outlined the development of a voluntary CME plan for the members of MSMA with an estimated budget of $19,750. MSMA would provide CME personnel and expenses. Each specialty on the Interspecialty Commission is now developing program standards.

Support Insurance For Newborn

— Heard the Legislative Committee report which stated that about 35 medically-related bills have been pre-introduced in the Missouri General Assembly. Some positions taken by the Council on new bills were to oppose a measure which would open the practice of acupuncture to lay practitioners and to support a bill which would provide health insurance coverage to the newborn.

— Heard a report from the Speaker of the House which asked Councilors to remind component medical societies that the deadline for insertion of Resolutions in the Handbook for the Annual Session is February 18.

MSMA-sponsored tours, seminars approved for 1974 by Council

Three MSMA-sponsored tours have been approved for 1974 by the Council.

The European Adventure, a 15-day tour of Switzerland, Austria and Germany, will conducted in late June by Intrav.

In late August, Marriott will handle a 9-day Grecian Tour, which includes visits to Athens and a cruise through the Grecian Islands.

The final 1974 tour will feature Marriott's 8-day trek to Barbadoes, in the Carribean, in late November.

Medical seminars will be available on all the tours.

Further information on each tour will be mailed directly to MSMA members as well as being published in future editions of MISSOURI MEDICINE.

For more information immediately, write to Tour Director, Missouri State Medical Association, Box 1028, Jefferson City, Mo. 65101.

Registration Form

"MMPAC Workshop"

Please register me for the "MMPAC Workshop," Saturday, February 2, 1974, at the Ramada Inn, Jefferson City.

Mail this card
today to:

NAME ____________________

ADDRESS ____________________

CITY ____________________

MMPAC
c/o MSMA
Box 1028
Jefferson City,
Missouri 65101

(Please make advance room reservations directly with Ramada Inn, Jefferson City)

'If physicians won't tell medicine's story...who will?'

The question in the above headline embodies the reason behind the first "MMPAC Workshop," scheduled for Saturday, February 2, 1974, at the Ramada Inn in Jefferson City.

Sponsored by the MSMA's Commission on Public Affairs, the "MMPAC Workshop" will offer a wide range of political information and know-how to members of the MSMA.

The impact of politics on medicine is obvious when you consider that 100 medically-related bills were introduced in the Missouri General Assembly last year and 2,500 medically-related measures were introduced in Congress. Additionally, many thousands of state and federal regulations which affect medicine are formulated each year.

What can be done about all this legislation? For starters, consider that in 1974:

* **17 State Senators will be elected.**
* **163 State Representatives will be elected.**
* **10 Missouri Congressmen will be elected.**
* **1 U.S. Senator from Missouri will be elected.**

"The reasons for a 'MMPAC Workshop' are sufficient to warrant participation by all interested physicians in Missouri," said Hubert A. Ritter, M.D., program Chairman.

"But are there enough INTERESTED physicians and Auxiliary leaders in Missouri willing to give up Saturday, February 2, to see what they can do to assist the medical profession in the vitally important political arena? I hope so!"

The Workshop has been scheduled from 9 a.m. to 3 p.m. on Saturday to avoid the fuel crisis and allow participants suffcent time to return home rather than staying overnight at the motel.

A special feature of the meeting will be a free luncheon which will conclude with a session, "Talk Back to Your State Medical Association." The panel will include the Officers and Councilors of the MSMA, who will be open to all questions from the floor. This will be the only session not concerned with partisan politics and should provide MSMA members the opportunity to find out how-and-why certain decisions are made that affect the MSMA.

A glance at the accompanying Workshop Program shows that both State and National legislative scenes will be covered along with information on how to be more effective in the political arena.

"MMPAC Workshop" Program

9:00 a.m.	**Welcome**	Hubert A. Ritter, M.D.
9:15 a.m.	**PAC Slide Show**	
9:30 a.m.	**Missouri Legislative Scene** *Current Situation* *What to Expect*	John I. Matthews, M.D.
10:30 a.m.	**How to Work with Legislators** *How Proposals Become Law* *"Key Personnel" Concept*	Mr. Royal O. Cooper
Noon	**Free Luncheon** *"Talk Back to Your State Medical Association"*	
1:30 p.m.	**National Legislative Scene**	
2:00 p.m.	**Organizing a Campaign** *Help Your Candidate Win* *Fund Raising*	Mr. Lee Mortenson
2:30 p.m.	**Status of National Health Insurance**	Dr. Ritter
2:45 p.m.	**MMPAC-AMPAC, Effective Political Action**	John N. Martin, M.D.

MSMA Delegates to consider Constitutional amendments on petitions, Speaker's office

Delegates attending the 116th Annual Session of the Missouri State Medical Association, April 4-7, 1974, at Crown Center in Kansas City, will vote on two amendments to the MSMA Constitution. These two amendments were presented at the 1973 Annual Session and, as provided by the Constitution, must be published twice preceding the 1974 meeting.

The first amendment amends Article IX of the Constitution to read as follows:

"Petition signed by 10% of the active members of the Association, including petitioners representing at least one-half of the component Medical Societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Asssociation responding will determine the question."

The second amendment amends Article IV of the Constitution by inserting a comma following the word "Association" and adding the following words, "the Speaker and Vice Speaker." This sentence would then read:

"The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past Presidents of the Association, the Speaker and Vice Speaker, who shall serve as delegates-at-large."

If the latter change in the Constitution is adopted, a corresponding change will be necessary in the Bylaws. The Constitution and Bylaws Committee has recommended the following amendment to the Bylaws:

"Chapter III, Section 2 of the Bylaws should be amended by inserting a comma and the following words "the Speaker and Vice Speaker" following the word "Association" in the last sentence. The sentence would then read, "All Past Presidents of the Association, the Speaker and Vice Speaker, shall serve as delegates-at-large."

CHPs Evaluate Expenditures

During the first six months of the State SSA-1122, a system whereby areawide CHPs evaluate many of the capital expenditure plans of hospitals, 88 applications have been submitted with total proposed capital expenditures of $140,717,141. Two applications totaling $2.4 million were issued "No Finding of Need" while 41 applications received "Finding of Need" recommendation. The remaining applications are being reviewed, according to the State CHP.

News-in-Brief

County Incentive Program

Notice has been sent to County Society Secretaries concerning the AMA's "Membership Incentive Program."

A county society will receive one-half of the first year dues of new AMA members. For example, if a society enrolls a new AMA member at $110, the society will receive $55. This also applies if a former AMA member whose membership has been terminated for 24 or more months rejoins AMA.

To qualify for the program, county societies are required to establish a permanent Committee on Membership and actively solicit memberships.

Dr. Bradshaw Elected

William D. Bradshaw, M.D., of Clinton, MSMA Councilor from the Sixth District, was recently elected Chairman of the Missouri State Board of Health.

Resolution Deadline Nears

MSMA members or County Societies desiring to introduce Resolutions at the 1974 Annual Session are reminded that February 18 is the deadline for insertion of Resolutions in the Delegates' Handbook.

Any Resolution to be introduced after that time must be made available to the House 24 hours before the Session in which it is to be introduced and at least 200 copies of the Resolution, or funding for same, must be furnished by the submitter.

The same procedure applies for the Second Session, but introduction requires two-thirds approval. Unanimous approval is needed for introduction at the Final Session.

Delinquency Date Advanced

The dues delinquency date for AMA membership has been changed from June 1 to April 30. County Societies have been advised that the MSMA can meet the AMA deadline only if the MSMA receives county dues by March 1.

The change was made to correct the nagging problem of a physician joining the AMA through his County and State Societies in early winter, yet not receiving notice of his AMA membership until mid-summer, when the AMA finally received the physician's dues.

Peloquin Resigns CHP

Edward J. Peloquin, Director of the Missouri Comprehensive Health Planning Agency since 1970, has announced his resignation effective February 1.

The patient with asthma or allergy: another type for Tylenol® (acetaminophen)

When the allergic patient has a condition requiring an analgesic, a new problem arises. "Idiosyncrasy to salicylates is not rare and is usually manifested by skin rashes and anaphylactoid reaction. Sensitivity to these drugs occurs more frequently in patients with asthma and allergy."[1] Moreover, the previous ingestion of aspirin without ill effects is no guarantee that subsequent use will not precipitate a severe reaction.[2]

TYLENOL (acetaminophen), on the other hand, presents little risk of allergic reaction, even in patients sensitive to aspirin,[3] making it the preferred analgesic for the allergic patient.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L.: Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961: abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

Tylenol®
(acetaminophen)

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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Sterile
Trobicin
spectinomycin hydrochloride
equivalent to 2 Gm spectinomycin
Upjohn
For intramuscular Use Only

acute gonorrhe

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit..

*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular
and **Trobicin**® 2 gm and 4 gm vials
sterile spectinomycin hydrochloride

e Trobicin
Trobicin (spectinomycin hydrochloride) Intramuscular Injection:
vials containing 5 ml when reconstituted luent.
vials containing 10 ml when reconstituted luent.
inocyclitol antibiotic active *in vitro* against rains of *Neisseria gonorrhoeae* (MIC 7.5 mcg/ml). Definitive *in vitro* studies have no cross resistance of *N. gonorrhoeae* n spectinomycin and penicillin.

ations: Acute gonorrheal urethritis octitis in the male and acute gonorrheal is and proctitis in the female when due eptible strains of *N. gonorrhoeae*.

aindications: Contraindicated in pa- previously found hypersensitive to spec- cin.

ings: Not indicated for the treatment of s. Antibiotics used to treat gonorrhea ask or delay the symptoms of incubating s. Patients should be carefully examined onthly serological follow-up for at least hs should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Caution: Federal law prohibits dispensing without prescription.

For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

patients with gonorrheal proctitis and for patients in geographic areas where antibiotic stance is known to be prevalent, initial treatment with 4 grams is preferred.

Preliminary Program
116th Annual Session

MISSOURI STATE MEDICAL ASSOCIATION

Crown Center Hotel, Kansas City **April 4-7, 1974**

Thursday, April 4

11:00 AM Registration of Delegates.
1:30 PM House of Delegates Meeting, opening session.
3:30 PM Reference Committee Meetings.
6:30 PM Missouri State Surgical Society Executive Council Meeting, Buttonwood Tree Inn, 4800 Main.

Friday, April 5

8:00 AM Registration.
9:00 AM General Session. *Professional Standards Review Organization (PSRO).*
Introduction: E. A. Stricker, M.D., St. James, MSMA President.
Speakers:
John M. Chenault, M.D., Member, Board of Trustees, American Medical Association.
PSRO Official to be announced.
10:30 AM Intermission to view exhibits.
10:30 AM Presiding: Clarence C. Cohrs, M.D., Moberly, President, Missouri State Allergy Association.
Participants:
Association Between Learning Disorders, Behavior Disorders and Allergy, James Hartwright, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
The Antigenic Deterioration Rate of Aqueous Ragweed Pollen Extracts, Josephine G. Brunidor, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
The Dual-Based System of Immunity, Norman T. Berlinger, M.D., New York, N. Y., Fellow, Clinical Immunology Service, Memorial Hospital and Research Associate, Sloan-Kettering Institute for Cancer Research.
The Immunologic Aspects of the Allergic Reaction, Daniel J. Stechschulte, M.D., Kansas City, Kan., Chairman, Section of Allergy and Immunology, University of Kansas Medical Center.
Electron Microscopy of Aphthous Stomatitis, Philip Carr Anderson, M.D., Columbia, Chairman and Professor, Dermatology and Allergy, University of Missouri-Columbia School of Medicine.
Rapid Determination of T-Cell Presence in Premature and Newborn Infants, Ronald Moyer, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
Sponsored by Missouri State Allergy Association.
*11:00 AM *Common Pediatric Gastrointestinal Problems.*
Giulio J. Barbero, M.D., Columbia, Professor and Chairman, Department of Pediatrics, University of Missouri-Columbia School of Medicine and Vice-Chairman, Executive Board of Directors, National Cystic Fibrosis Research Foundation.
Sponsored by Missouri Chapter, American Academy of Pediatrics.
*11:00 AM *Gastrointestinal Diseases.*
Participants:
The Use of Endoscopy in Upper GI Bleeding, Burnell Landers, M.D., Gastroenterology, Kansas City.
Indications for and Results of Colonoscopy (What Is Colonoscopy?), Walter Harvey Jacobs, M.D., Gastroenterology, Kansas City.
Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).
*11:00 AM *Program on Psychiatry.* Sponsored by Missouri Psychiatric Association.
*11:00 AM *Program on Surgery.* Sponsored by Missouri State Surgical Society.
12:30 PM Missouri University Alumni Luncheon.
* 2:00 PM Presiding: Jean Chapman, M.D., Cape Girardeau, President-Elect, Missouri State Allergy Association.

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* Concurrent Sessions.

Participants:

Pulmonary Hypersensitivity Syndrome, Raymond Slavin, M.D., St. Louis, Professor of Internal Medicine and Director, Section of Allergy and Immunology, St. Louis University School of Medicine.

Contemporary Considerations in Clinical Immunology, Norman T. Berlinger, M.D., New York, N. Y., Fellow, Clinical Immunology Service, Memorial Hospital and Research Associate, Sloan-Kettering Institute for Cancer Research.

Disodium Cromoglycate in Pediatric Office Practice, Lester Wall, M.D., St. Louis, Assistant Clinical Professor of Pediatrics, St. Louis University School of Medicine.

Thermography in Clinical Allergic Diseases, Laurie Smith, M.D., St. Louis, Fellow, Section of Allergy and Immunology, St. Louis University School of Medicine.

The Concepts of Allergic Treatment Including Hyposensitization and Regulation of Mediator Release, Daniel J. Stechschulte, M.D., Kansas City, Kan., Chairman, Section of Allergy and Immunology, University of Kansas Medical Center.

Question and Answer period.

Sponsored by Missouri State Allergy Association.

* 2:00 PM Program Sponsored by Missouri Heart Association, Inc.

* 2:00 PM *Pulmonary Diseases.*

Participants:

Understanding Blood Gases, George S. Devins, M.D., Pulmonary Diseases, Kansas City.

Management of C.O.P.D., Robert A. Raich, M.D., Internal Medicine, Kansas City.

Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).

* 2:00 PM *Program on Psychiatry.* Sponsored by Missouri Psychiatric Association.

* 2:00 PM *Program on Surgery.* Sponsored by Missouri State Surgical Society.

3:30 PM **Intermission to View Exhibits.**

4:00 PM **House of Delegates,** second session.

5:30 PM Missouri State Medical Foundation Annual Meeting.

6:00 PM Reference Committee Meetings.

6:00 PM Dinner Meeting: Missouri State Allergy Association.

6:30 PM Dinner Meeting: Missouri State Surgical Society.

Saturday, April 6

8:00 AM Registration.

* 9:00 AM *Program on Anesthesiology.* Sponsored by Missouri Society of Anesthesiologists.

* 9:00 AM *Cardiovascular Diseases I.*

Participants:

Bedside Evaluation of Cardiovascular Function, James E. Crockett, M.D., Cardiovascular Diseases, Kansas City.

Heart Sounds, Carlton L. Shmock, M.D., Cardiovascular Diseases, Kansas City.

Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Division).

* 9:00 AM *Program on Ophthalmology.* Sponsored by the Missouri Ophthalmological Society, Inc.

* 9:00 AM *Program on Surgery.* Sponsored by Missouri State Surgical Society.

* 9:00 AM *Program on Urology.* Sponsored by Federation of Missouri Urologists.

10:30 AM **Intermission to View Exhibits.**

*11:00 AM *Program on Anesthesiology.* Sponsored by Missouri Society of Anesthesiologists.

*11:00 AM *Cardiovascular Diseases II.*

Participants:

Medical Management of Acute Myocardial Infarction, Keith H. Averill, M.D., Cardiovascular Diseases, Kansas City.

Surgical Management of Acute Myocardial Infarction, William A. Reed, M.D. and Duncan A. Killen, M.D., Cardiovascular Surgery, Kansas City.

Sponsored by Missouri Society of Internal Medicine and American College of Physicians (Missouri Region).

*11:00 AM *Transmission of Disease by Blood Transfusion.*

William L. Bayer, M.D., Kansas City, Medical Director, Community Blood Center of Kansas City.

Moderator: Thomas J. Fritzlen, M.D., Kansas City.

Sponsored by Missouri Society of Pathologists, Inc.

*11:00 AM *Evaluation and Management of Low Back Disorders.*

Rene Cailliet, M.D., Los Angeles, Calif., Chairman and Professor, Department of Rehabilitation Medicine, University of Southern California.

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* Concurrent Sessions.

The Multidisciplinary Approach to the Treatment of Arthritis, Charles R. Peterson, M.D., Columbia, Professor and Chairman, Department of Physical Medicine and Rehabilitation, University of Missouri-Columbia School of Medicine.
The Rehabilitation of the Stroke Patient—When, Where and How, Franz U. Steinberg, M.D., St. Louis, Director, Department of Rehabilitation Medicine, The Jewish Hospital of St. Louis.
Moderator: Franz U. Steinberg, M.D., St. Louis.
Sponsored by Physical Medicine and Rehabilitation.

*11:00 AM *Program on Radiology.* Sponsored by Missouri Radiological Society.
12:30 PM 50-Year Club Luncheon.
Missouri Ophthalmological Society, Inc., Luncheon.
Physiatrics Luncheon.
12:45 PM MSMA General Luncheon.
Guest Speaker—William J. Cason, Clinton, President Pro-Tem, Missouri Senate.
* 2:30 PM *Tumor Immunology.*
Moderator: Andrew McCanse, M.D., Kansas City.
Participants:
Basic Science Aspects of Clinical Immunology, Paul Morse, Ph.D., The University of Kansas Medical Center, Kansas City, Kan.
Immunology in the Diagnosis of Malignant Disease, George Pierce, M.D., The University of Kansas Medical Center, Kansas City, Kan.
Immunotherapy of Solid Tumors, William R. Jewell, M.D., The University of Kansas Medical Center, Kansas City, Kan.
Sponsored by American Cancer Society, Missouri Division.
* 2:30 PM *Program on Dermatology.* Sponsored by Missouri Dermatological Society, Inc.
* 2:30 PM *The Family Physician and the Management of ENT Problems.*
Moderator: Lindsay L. Pratt, M.D., St. Louis.
Panel Participants:
Nose Bleeds—Robert Hazen, M.D., Kansas City.
Sinus Disease—Carl Ehrlich, M.D., St. Louis.
Middle Ear Disease—Donald Joseph, M.D., Columbia.
The Dizzy Patient—Malcolm Stroud, M.D., St. Louis.
Maxillofacial Tumors and Injuries—Floyd Barnhill, M.D., Springfield.
Sponsored by Missouri Ear, Nose and Throat Association, Inc.
* 2:30 PM *Metabolic Diseases.*
Participants:
Management of Labile Diabetes, Jerome A. Grunt, M.D., Pediatric Endocrinology, Kansas City.
Diagnosis and Treatment of High Blood Lipids, Ralph R. Hall, M.D., Internal Medicine, Kansas City.
Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).
* 2:30 PM *Program on Radiology.* Sponsored by Missouri Radiological Society.
4:00 PM Intermission to View Exhibits.
5:00 PM St. Louis University Medical Alumni Cocktail Party.
5:00 PM Washington University Medical Alumni Cocktail Party.
6:30 PM Social Hour for Those Attending Banquet.
7:15 PM Annual Banquet in Honor of Past-Presidents.

Sunday, April 7

7:30 AM House of Delegates. Breakfast and Final Session.

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* Concurrent Sessions.

IMPROVED ACCIDENT & HEALTH PROGRAMS

The Disability Income Policy sponsored by the Missouri State Medical Association since 1943 has now been made GUARANTEED RENEWABLE and income benefits are available up to $300.00 weekly to members under age 56 subject to acceptance by the Company.

Also, the Major Hospital and Nurse Expense Program offers higher limits with increased Room & Board Benefits.

For Complete information call or write to:

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WASHINGTON

Two more major national health insurance proposals have been thrown into the Congressional hopper, bringing the total to eight with at least two more waiting in the wings, including that of the Administration.

Chairman Harley O. Staggers (D-W.Va.) of the House Commerce Committee has introduced his own national health insurance proposal (NHI), saying hearings will be held on his bill in the coming year.

The second new NHI proposal came from Senate Republican leader Hugh Scott (R-Pa.) and Charles Percy (R-Ill.).

Staggers' National Comprehensive Health Benefits Act of 1973 would provide comprehensive health care benefits and complete protection against the costs of catastrophic illness to all. It would be financed by a combination of contributions from employers, the federal government and individuals, scaled to income. The federal funds are for health insurance and catastrophic illness benefits for the poor and near-poor.

The introduction came shortly before hearings on NHI by the Commerce Subcommittee on Public Health and Environment.

It is the first major NHI proposal to be referred to the Interstate and Foreign Commerce Committee rather than the Committee on Ways and Means, Staggers noted, adding that it is the first NHI proposal by a chairman of a major committee in the House.

Major features of the proposal, as described by Staggers, are as follows:

—a strong role for state governments in the development and administration of the program;

—incentives for the creation and use of Health Maintenance Organizations;

—a six-year transitional period for orderly development;

—the use of existing private health insurance carriers for administration of the insurance provisions;

—and the fact that the program builds on, rather than federalizing, the existing health care system.

The bill provides that newly created State Health Commissions (SHC's) would be responsible for the actual administration of much of the program, including standard setting and quality control; assisting in the development of Health Maintenance Organizations (HMOs); and administration of some of the insurance provisions. Existing private health insurance carriers would be used to underwrite most of the legislation's insurance benefits. The development and use of HMOs would be encouraged through additional direct developmental assistance and through a 10% federal subsidy of HMO premiums.

Within two years of enactment, all aged, low income and unemployed individuals and families would be provided coverage for basic health services. Within four years of enactment, all individuals and families would be provided coverage for basic health services and the costs of catastrophic illness. Within seven years of enactment, all individuals and families would be provided coverage for comprehensive health care benefits and the costs of catastrophic illness.

Senator Scott said his two-part "Health Rights Act" would provide for inpatient protection for all persons suffering major illness and would set up an outpatient health maintenance insurance plan. It would replace both the Medicare and Medicaid programs now in effect. Scott added that he believed his bill was "must legislation" for this session of Congress "because its goal is to serve every American at a critical time."

Under the Scott-Percy Health Rights Act, both the inpatient and outpatient plans would be administered by insurance carriers or other public or private agencies on a regional basis, under contract with the newly created Office of Health Care within the Department of Health, Education and Welfare.

The inpatient, "major illness" protection differs from traditional catastrophic plans by covering all costs above each family's health cost ceiling, which is determined by a formula taking into account both family income and family size. Money for the plan would be financed in part through the present health insurance portion of Social Security payroll taxes and in part through general revenues.

(Continued on page 15)

BURTON H. BAKER, M.D. *and*
ROLINDA B. BAKER, *Columbia*

Ellis Fischel, Dedicated Missourian

Special Article

Anyone traveling on Interstate 70 through Columbia will notice a singular, seven-story brick structure rising from a great expanse of lawn. If the traveler were to look at the unobstrusive signs, he would learn that this 33-year-old structure is the Ellis Fischel State Cancer Hospital.

For thousands of people, the signs are unnecessary. They can find the hospital almost by instinct. These people are the more than 39,000 residents of the state of Missouri who are patients who have received diagnosis or treatment in this institution.[1]

This hospital was considered outstanding when it was opened. Since its founding, it has remained a leader in both the diagnostic and therapeutic techniques of treating malignant disease. Ellis Fischel State Cancer Hospital was the second state-sponsored hospital for the treatment of cancer in the United States.[2] Originally, it was to provide care for indigent Missourians suffering from cancer. Now, all Missourians are eligible for treatment at the hospital.

This sandstone-colored edifice is named for Ellis Fischel, M.D., the first Chairman of the Missouri State Cancer Commission. This surgeon worked to establish an excellent cancer control program in Missouri.[3]

Ellis Fischel was born in St. Louis on a hot, muggy day in July, 1883. He remained there throughout his childhood and completed study at Smith Academy, a high school,[4] before traveling to Boston to attend Harvard.

The authors present a brief biographical review of Ellis Fischel, dedicated Missouri surgeon who pioneered in the treatment of cancer and for whom Missouri's first state cancer hospital was named. Dr. Baker is a Post-Residency Trainee at Ellis Fischel State Cancer Hospital and Cancer Research Center. Ms. Baker is a Graduate Student, Department of Community Health and Medical Practice, University of Missouri. This work was supported by Clinical Cancer Training Grant CA-08018 from the National Cancer Institute.

One classmate at Harvard was Franklin Delano Roosevelt.[5] Others at Harvard described him as stoic, courageous and always dignified.[6] He enjoyed baseball enough to become an outstanding baseball player[6] and received the Gold Bat Award for his excellence.

Since Ellis was the son of the distinguished St. Louis internist, Washington Fischel, a medical career seemed natural.[5] He returned to St. Louis to attend Washington University Medical School, where he received his medical degree in 1908.[4]

Dr. Fischel's independent spirit became apparent after an internship at St. Louis City Hospital. He decided to free himself from family tradition and pursue a career in surgery.

Dr. Fischel joined many other young American physicians who were learning the fine points of their art in the great European medical centers of the day. He studied in Berlin, Munich, Vienna and Berne.[7, 8] When he returned to the United States he married Marguerite Kauffman of St. Louis. They were the parents of two children.

He then began the refinement and training that any physician receives by practicing medicine and surgery. His reputation as a distinguished surgeon and ". . . a national leader in cancer research, treatment and hospitalization"[9] became established. Other physicians became aware of his success at treating cancer patients, even with the limited techniques then available to him.[8]

Dr. Fischel shared his expertise with other physicians by writing 31 scientific papers. The majority of these papers dealt with the treatment of cancer.[10]

Young physicians from St. Louis University and Washington University benefitted from his teaching. Dr. Fischel was ultimately appointed Associate Professor of Clinical Surgery at Washington University. He also worked actively for development of postgraduate medical teaching programs in St. Louis hospitals.

His inexhaustible energy enabled him to assist in the founding and growth of the St. Louis Clinics and to participate in many cancer societies as well. He recognized the magnitude of the role cancer played in our society and sought to diminish this role.

Dr. Fischel's interest led him to serve on the Board of Directors of both the American Society for Control of Cancer and the Barnard Free Skin and Cancer Hospital. He also made time to chair both the Committee on Cancer of the Missouri State Medical Association and the State Cancer Commission.[8]

As Chairman, Dr. Fischel participated in determining the location, planning and construction of the cancer hospital that bears his name.[8] He expended a great amount of effort to establish this hospital for indigent cancer patients in Missouri that marked all of his projects. He was impressed with the urgent need for such a facility, so he enlisted the aid of Gov. Lloyd C. Stark.[9]

Ellis Fischel worked for the passage of the bill which would begin the state of Missouri's cancer control program and create the cancer hospital.[11] This bill was finally passed by the 59th General Assembly of the state of Missouri.

Dr. Fischel planned to have scientific study of the etiology, symptomatology and diagnosis of cancer at the new hospital. He also hoped to expand Missouri's cancer control programs through diagnostic tumor clinics in Missouri's larger cities.[3]

He did not live to see his plans carried out. While on Cancer Commission business on May 14, 1938, Dr. Fischel was killed instantly in an automobile accident.[7] His death came before his dream was fully realized, but not before he knew he had succeeded in his plans for fighting cancer in Missouri.[12]

People did not forget Ellis Fischel. The hospital for which he had worked was named in his honor.[7] Because of his outstanding work, the Barnard Free Skin and Cancer Hospital honored him with a bronze plaque.[13] He is one of only four people honored with such a plaque.

Dr. Fischel did not forget those who had worked with him. He had a large store of radium which he used in cancer therapy. He left this radium to a trust company. The income from the fees for using the radium was given to the secretary for the group of offices in the building in which Dr. Fischel had his office.

Even this generous gesture was tempered with concern for those who could not afford treatment. These people were to be treated without charge.[14] Contributions to a fund in Dr. Fischel's name at the Barnard Free Skin and Cancer Hospital provided enough money to enable the hospital to buy radium for the treatment of cancer.[15]

This brilliant surgeon, devoted educator and humanitarian died in the middle of an active, useful life. He had done all he could to improve the health of fellow Missourians and all people. His contributions to fighting cancer were so great that death could not halt the work he had started.

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Washington

(Continued from page 13)

The outpatient plan would be financed in part through family premium payments which would be supplemented in whole or part with federal payments for low-income families. Employers could arrange to finance all or part of their employees' premiums.

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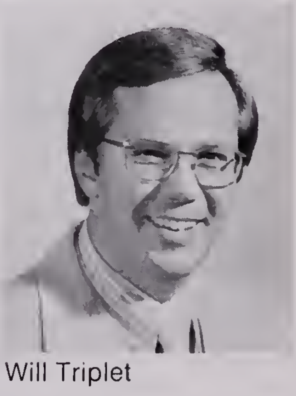
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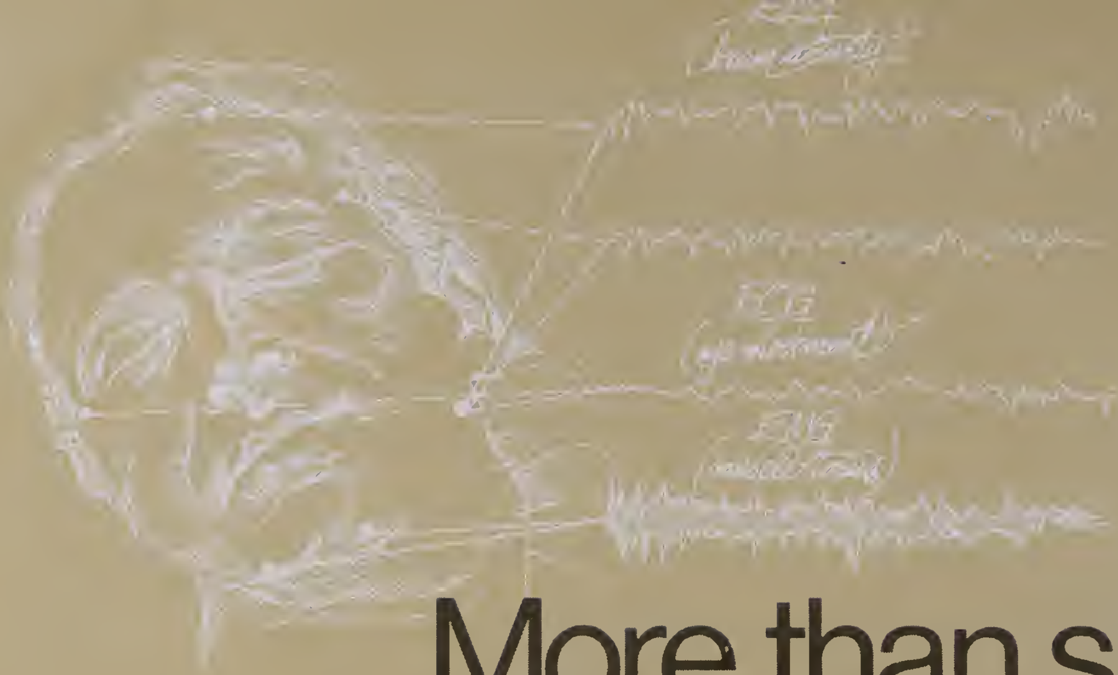

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nt Statement on Antisubstitution Laws and Regulations

The purpose of this statement is ffirm the support of the participat- organizations for the laws, regula- s and professional traditions which ibit the unauthorized substitution rug products.

Traditionally, physicians, den- and pharmacists have worked peratively to serve the best inter- of patients. Productive coopera- has been achieved through ual respect as well as a common cern for the ideals of public ice. This mutual respect has been ected, in part, by joint support the years for the adoption and rcement of laws and regulations cifically prohibiting unauthorized stitution and encouraging joint ussion and selection of the ce of supply of drug products. basic principles of medical, den- nd pharmacy practice are thus zed and preserved in the interest atient welfare.

The antisubstitution laws have obstructed enhancement of the essional status of pharmacy any e than they have in and of them- es guaranteed absolute protec- from unsafe drugs, or freed sicians, dentists and pharmacists their responsibilities to patients. practical matter, however, such and regulations encourage inter- essional communications regard- drug product selection and assure profession the opportunity to cise fully its expertise in drug ge, to the advantage of patients.

Physicians and dentists should rged to increase the frequency regularity of their contacts with rmacists in selection of quality products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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EGBERT R. BORJA, M.D. *and*
REGINALD P. PUGH, M.D., *Columbia*

Management of Hypercalcemia Secondary to Malignancy

Hypercalcemia may be a serious complication of malignant disease. It is being recognized with increasing frequency during the course of malignancy because of the routine use of multichannel chemical analyzers. Therefore, physicians must be increasingly aware of the management of this potentially fatal complication.[1]

Mechanisms of Hypercalcemia

Mechanisms producing hypercalcemia associated with malignant disease are varied. Most commonly, hypercalcemia is associated with wide spread bone metastases.[2] Resorption of large amounts of calcium secondary to extensive bone destruction is the most commonly stated mechanism. This type of hypercalcemia is seen most frequently in carcinoma of the breast and multiple myeloma, but it also is seen in other types of malignancy frequently metastasizing to bone, namely, bronchogenic carcinoma, hypernephroma and lymphoma. Hypercalcemia also may result from the elaboration of parathormone-like polypeptide by the primary tumor unassociated with the presence or absence of metastases. It is most frequently observed with carcinoma of the kidney and bronchogenic carcinoma. Also, vitamin D-like sterols may be elaborated, particularly with carcinoma of the breast.[3] As in patients with other chronic disorders, prolonged immobilization of the cancer patient may result in hypercalcemia.

In addition, hypercalcemia commonly occurs in patients secondary to administration of the various sex hormones.[4, 5] Each of the hormones most commonly used in the treatment of breast carcinoma, namely estrogens, androgens and progestins, may induce hypercalcemia.[4-9] The incidence of hypercalcemia with the use of estrogens or androgens approximates 11%, while progestin-induced hypercalcemia may be seen in 15% of patients so treated.[5] This complication of hormone therapy usually occurs within the first week of administration. Therefore, patients should be carefully monitored initially for symptoms of hypercalcemia and for elevation of serum calcium levels.

Symptoms of hypercalcemia may be varied and nonspecific. They include nausea, vomiting, polyuria, polydipsia, constipation and mental changes.

This article presents a study of various causes of hypercalcemia and malignancy and cites principles of management and appropriate therapy. Dr. Borja is Assistant Scientist at the Cancer Research Center. Dr. Pugh is Chief of Internal Medicine at Ellis Fischel State Cancer Hospital and Senior Scientist and Section Chairman of Internal Medicine, Cancer Research Center. This investigation was supported by General Research Support Grant FR-05618 from the National Institute of Health.

TABLE 1

26 CASES OF HYPERCALCEMIA SECONDARY TO MALIGNANCY AT EFSCH IN 1972

Primary Diagnosis	*Number of Cases*
Ca. of the breast	8
Multiple myeloma	6
Ca. of the lung	3
Ca. of the cervix	2
Ca. of the kidney	1
Epidermoid ca. of the vocal cords	1
Metastatic epidermoid ca. (unknown primary)	1
Hemangiopericytoma	1
Ca. of the ovary	1
Adenocarcinoma of the prostate	1
Abdominal carcinomatosis (unknown primary)	1

Hypertension is frequently observed. Most life-threatening complications of hypercalcemia are sudden death due to cardiotoxicity and renal failure, which may be irreversible in cases of prolonged hypercalcemia. There often is no correlation between the serum calcium level and the severity of the clinical picture. The Ellis Fischel State Cancer Hospital (EFSCH) does not have access to routine multichannel chemical analysis. Therefore, only 771 calcium determinations were done at the EFSCH in 1972. Patients in twenty-six cases secondary to various malignancies were discovered to have hypercalcemia. Table 1 shows the various primary sites of malignancy associated with hypercalcemia.

Principles of Management

The principles of therapy for control of hypercalcemia secondary to malignancy include the following:

1. General supportive measures are immediately instituted to correct frequently observed dehydration and electrolyte imbalances secondary to nausea and vomiting and renal impairment with water, sodium and chloride loss. Therefore, rehydration with saline, correction of electrolyte imbalances, hyperuricemia and modifications of medications dependent on normal renal function such as digitalis preparations are in order.[10-12]

2. If a specific cause for hypercalcemia can be identified, treatment may be directed appropriately, i.e., offending hormone preparations should be immediately stopped. Chemotherapeutic agents with a reasonable chance for tumor responsiveness may be employed, especially in cases with minimal symptoms and complications of hypercalcemia.

3. Decreased calcium intake may be employed. However, dietary management has very little to offer to correct hypercalcemia associated with malignancy since many patients already have anorexia, nausea and vomiting and the source of the elevated serum calcium is most often due to mobilization of calcium from bone rather than from excessive gastrointestinal tract absorption.[8, 10]

4. Urinary excretion of calcium may be increased by utilization of normal saline,[2] furosemide[13] or sodium sulfate.[14, 15]

5. Reduction of ionized plasma calcium may be accomplished with medications such as corticosteroids,[8] inorganic phosphates,[16-18] mithramycin,[19, 20] calcitonin[21] and EDTA.[22] This group of medications is most commonly used for rapid reduction of elevated serum calcium levels, particularly corticosteroids and inorganic phosphates.

Mechanisms of Action of Useful Agents

The mechanisms of action of medications used to reduce ionized plasma calcium levels are listed below.

Normal saline increases glomerular filtration after adequate rehydration. Sodium competes with calcium at the reabsorption site in the proximal convoluted tubule resulting in calcium diuresis. Its use is contraindicated in patients presenting with congestive heart failure.

Furosemide is a potent natriuretic agent which blocks sodium and calcium reabsorption at the proximal convoluted tubule and ascending loop of Henle.[13] If used primarily in the treatment program for reduction of hypercalcemia, urinary output should be monitored closely and serum and urine electrolytes done at frequent intervals to assure adequate replacement.

Secondary hypomagnesemia may result unless magnesium is replaced. Occasionally, temporary loss of hearing may occur during rapid intravenous administration of furosemide, particularly in the presence of impaired renal function.

The mechanisms of action of corticosteroids decreasing serum calcium levels is not clear. *Corticosteroids* reduce the absorption of calcium from the gastrointestinal tract and may inhibit tumor growth, thereby possibly reducing a parathormone-like polypeptide if present.[8] They also may decrease renal tubular absorption and bone turnover. A slow decrease in serum calcium concentration usually follows the use of steroids. Corticosteroids are best used in combination with normal saline or adequate rehydration and oral phosphates. This combination is particularly useful in patients with lymphoma, carcinoma of the breast and multiple myeloma.

Inorganic phosphates may be utilized in oral or intravenous forms depending on the severity of the clinical presentation. The main indication of intravenous inorganic phosphates is in the treatment of hypercalcemic crisis.[16-18] Patients may manifest intractable nausea and vomiting, stupor, coma and dehydration. Their use also is indicated in patients whose response to conservative management is minimal. Rapid reduction of plasma calcium during infusion of phosphates occurs with steady decline even after termination of infusion. The maximum effect is observed one to five days after infusion. The suppressed level of plasma calcium can be maintained by repeated infusions or by the use of oral phosphates. Extreme caution should be exercised in administering inorganic phosphates intravenously. Generally, an infusion should be given over an eight-hour period. Rapid rate of infusion, especially in the presence of renal failure, may result in hypotension, acute renal failure or prolonged hypocalcemia. Excessive administration may result in extraskeletal calcification and, rarely, calcification along the course of the veins used for infusion.[14, 15]

Sodium sulfate is not readily available in intravenous solution and must be given in large quantities in order to be effective. Calcium diuresis probably is produced by rehydration with subsequent increase in glomerular filtration rate, competition with calcium for reabsorption sites and the formation of nonreabsorbable complexes.[2, 18, 23, 24] With diuresis, there is a rapid decline of serum calcium starting three to four hours after infusion. Normal serum calcium is usually attained five to nine hours after termination of sodium sulfate infusion. However, there is a rapid return of calcium concentration to pretreatment levels. Sodium sulfate is contraindicated in hypertensive and elderly patients.

Mithramycin is a chemotherapeutic agent derived from Streptomyces tanashiensis. It acts by inhibiting the effect of parathormone on the osteoclast. During infusion, there is prompt and sustained decrease in the serum calcium concentration. The depressed levels of serum calcium may last anywhere from two to 24 days. Serious toxicity may be incurred including thrombocytopenia.

In life threatening situations, *ethylenediamine tetraacetic acid* (EDTA) may be indicated.[6] EDTA is a powerful chelating agent of calcium and causes rapid reduction of plasma calcium during infusion. However, a rebound elevation of plasma calcium is observed following termination of the infusion. Aside from pain at the site of injection, the EDTA complex may damage the renal tubules with repeated infusions.

Calcitonin is indicated in hypercalcemic patients with severe renal failure. However, it is not readily available. It probably reduces plasma calcium level by inhibiting bone resorption.[21]

Table 2 indicates the agents commonly used at EFSCH for the management of hypercalcemia and possible dosage schedules and methods of administration.

In summary, a recommended plan for the management of hypercalcemic patients with minimal symptoms might include the following:

1. Low calcium diet.
2. Rehydration with normal saline (minimum of 3 liters/24 hours), or an equivalent oral intake.
3. Oral phosphates (Fleet Phosphosoda 1 tsp tid).
4. Furosemide, 40 mg-100 mg IV push, bid, after adequate rehydration.
5. Corticosteroids, at least 60 mg-80 mg prednisone equivalent per day, either orally or incorporated in the intravenous fluids as indicated.

In more severe clinical presentations or hypercalcemic crisis, initial treatment might consist of the following:

1. Rehydration with normal saline.
2. Furosemide administered IV push after rehydration.
3. Corticosteroids incorporated in the IV infusion.
4. Inorganic phosphates infused over eight hours and/or the use of Mithramycin.

The choice of drugs in the management of hypercalcemia may be based on the physician's familiarity with drugs available, the level of consciousness of the patient, the degree of renal or cardiac complications or both and the prospects for a definitive treatment program directed at the primary causative disease. Reduction of the plasma calcium is a temporary measure to prevent the occurrence of fatal hypercalcemic complications in patients whose malignancy may be amenable to surgical, radiotherapeutic or chemotherapeutic induction of remission. Unless treatment is directed at the primary cause of hypercalcemia, this complication of malignant disease will almost invariably recur.

TABLE 2

AGENTS COMMONLY USED FOR THE MANAGEMENT OF HYPERCALCEMIA AT EFSCH

Agent	*Dose*	*Method of Administration*	*Contraindications*
Normal saline	Minimum of 3 liters per 24 hrs	IV	Congestive heart failure, hypertension, renal insufficiency
Furosemide*	40-100 mg. in AM Determine electrolyte both serum and urine Correction of electrolyte and fluid loss due to urinary output 40-100 mg in PM	IV	Renal insufficiency
Corticosteroids			
1. Hydrocortisone†	250-500 mg/24 hours	Incorporated with the normal saline	History of active peptic ulcer
2. Methyl prednisolone‡	60-125 mg/24 hours		
Inorganic phosphates			
(oral)§	1 tsp tid	Oral or per gastric tube	
(IV)‖	50 millimols (8 ml) in 1000 ml. of normal saline per 24 hours	8 hour IV infusion	Renal insufficiency
Mithramycin#	25 mcg/kg body weight, single dose PM	8 hour IV infusion or IV push	Bleeding disorder, renal insufficiency, liver impairment

* Furosemide—Lasix (Hoechst Pharmaceuticals)—20 mg vial.
† Hydrocortisone—Solu-Cortef (Upjohn)—500 & 1000 mg vial.
‡ Methyl prednisolone—Solu Medrol (Upjohn)—40 & 125 mg vial.
§ Fleet phospho-soda—5 ml = 900 mg sodium phosphate.
‖ Potassium Phosphate (McGaw)—30 ml vial.
Mithramycin—Mithracin (Pfizer)—2.5 mg vial.

SUMMARY

The management of hypercalcemia secondary to malignancy is outlined and was presented in part at the Ellis Fischel State Cancer Hospital-Cancer Research Center Professional Program on May 12, 1973. Various causes of hypercalcemia and malignancy are presented. Principles of management are cited and appropriate therapy recommended depending on the severity of the clinical presentation.

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JOHN S. SPRATT, JR., M.D., ***Columbia***

Your Behavior and Cancer

THE COMPREHENSIVE REPORT of the National Panel of Consultants on the Conquest of Cancer prepared for the Committee on Labor and Public Welfare of the United States Senate made a very significant observation in stating that "the results so far of epidemiological research strongly suggest that variations in exposure to environmental agents and in social practices are largely responsible for variations in the incidence of cancers among different groups of people. Therefore, if such environmental exposures and social practices could be identified and eliminated, the majority of cancers in man might be prevented."

The prevention of cancer by this method is a very complicated process requiring much detailed and time-consuming scientific detective work to identify the causative factors and to eliminate the factors and associated social practices. Prevention in an individual man will never be possible without the knowledgeable and lifelong practices that will reduce the chances of developing cancer. The purposes of this article are to identify those individual behavioral practices that should reduce an individual's chances of being exposed to factors and practices known to increase the incidence of cancer.

More than 30 recent reports have indicated a relationship between various forms of cancer and diet. Organs involved are usually those of the digestive tract, but diet also has been associated with cancer in other parts of the body. Food may contribute to cancer in several ways.

The first is by the presence of cancer-inducing chemicals in the food itself. Pesticides such as DDT are known to produce tumors of the lung and lymphoid organs when given to experimental animals. Concern for man has centered on the finding that fish in many parts of the country have significant levels of the pesticide in their tissues, as do red meat supplies and milk. These findings may account for the results of studies which have shown that the average person in the United States has 12 parts per million of DDT in his fatty tissue.

Sodium cyclamate, an artificial sweetener, came under scrutiny as a possible danger to humans when large doses given to animals yielded a breakdown product which caused chromosome damage and bladder cancer in rats.

Benzpyrene, a potent cancer-causing agent, has been found in smoked foods, charcoal-broiled steaks, bread and roasted coffee beans. Concentrations of benzpyrene in home-smoked foods have been reported to be 20 times higher than in factory-smoked products. One investigator has used these results to support evidence of a relationship between eating home-smoked foods and the high incidence of stomach cancer in Iceland.

Chemical compounds called nitrosamines also have been implicated as likely agents in causing many cancers. Nitrosamines are present in some foods, but also can be manufactured in man's own intestinal tract from compounds that are not carcinogenic (cancer producers), such as nitrates and secondary amines. Bacteria are involved in the conversions. It has been suggested that man should reduce his intake of foods and drugs likely to form nitrosamines in the intestines. Foods containing nitrites include ham, corned beef, bacon and most canned and smoked fish and meat. Most tranquilizers, antihistamines, antimalarials, appetite control agents, some hypoglycemic (low blood sugar) agents and some antibiotics fall in the category of drugs which interact easily with nitrites to form nitrosamines. Other common substances which interact easily with nitrites are beer, wine and tobacco smoke.

Another class of suspected cancer-causing agents includes the so-called natural by-products or metabolites of molds and fungi. One of the most potent, aflatoxin, causes liver cancer when included in the diet of test animals. Legumes (peanuts, soybeans), grain (corn, wheat) and aged meats (sausage, salami) are all prime candidates for aflatoxin contamination. It appears that in humans, a healthy liver helps protect the body from this compound by converting the aflatoxin into a harmless form which is subsequently excreted. In certain areas of the world, aflatoxin contamination has been implicated as a possible cause of liver cancer. A liver toxin capable of producing tumors also has been isolated from another common fungus, Penicillium rubrum (the antibiotic, pencillin, is not implicated), which has been found to contaminate rice in Japan.

Several plants and plant components are known to cause cancer. An example of a cancer-inducing plant component is cycasin present in

The irritations of man's day are often reflected in his gut.

The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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diphenoxylate hydrochloride . . . 2.5 mg.
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atropine sulfate . . . . 0.025 mg.

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An extensive literature exists that supports the various recommendations, though a controlled study to verify the value of every recommendation in man in a scientifically unequivocal fashion would be practically impossible to accomplish because of the multiplicity of uncontrollable factors involved and the very long periods of time required to verify changes in the incidence of cancer.

Dr. Spratt, who is Director of the Cancer Research Center, has been designated Coordinator for the Cancer Control Program of the state of Missouri by joint appointment of the Board of Health and the State Cancer Commission.

Suggestions for further improvement in this article are solicited by the author to help make it a more effective and current document for public education.

the cycad nut. (The cycad nut is chewed by people in some areas of the world.) Cycasin is converted by bacteria into an active component responsible for cancer. This carcinogen is closely related to the nitrosamines previously mentioned. Another plant component, safrole, was found to produce liver tumors when given in high doses to rats. It was used as flavoring in root beer and sarsaparilla until this was discovered. In Africa, it is suspected that bush teas containing toxic alkaloids may contribute to the high incidence of liver and esophageal tumors among natives.

Consumption of coffee and sugar has recently been investigated in relation to cancer incidence. Consumption of both has been correlated with prostatic cancer. Excessive sugar intake also was found to be related to breast, ovarian, bladder, intestinal and rectal malignancy. There is varying evidence that a high consumption of sugar is a contributory factor in several human diseases besides cancer—notably dental caries, obesity, coronary thrombosis, diabetes and certain diseases of the skin, digestive tract and the joints. Attention also has been focused on the caffeine in coffee, tea and carbonated soft drinks as a possible carcinogen.

In the United States, a high correlation between oral cancer and excessive alcohol consumption has been reported.

In addition to possible carcinogenic contaminates in individual foods, diet as a whole is currently being evaluated in relation to the incidence of several types of cancer. There seems to be a relationship between the quantity of food eaten and cancer. Individuals who overeat or are overweight when past middle age are more likely to die of cancer than persons who are average weight or less. In contrast, persons with protein, vitamin or mineral deficiencies or general malnutrition are more susceptible to cancers of the liver, gall bladder and upper alimentary tract.

Epidemiologic surveys have shown that the incidence of colon cancer is greater in Western Europe and the United States than in East Africa, Asia and South America. Attempts have been made to relate these findings to dietary differences. People living in the industrialized Western countries tend to eat larger amounts of fat, animal protein and refined carbohydrates such as granulated sugar. In the developing areas, people eat largely vegetarian diets with little fat or animal protein. The intestines of these people in the Western groups contain more bacteria capable of converting fats and steroids to cancer causing compounds. It is thought that refined carbohydrates, such as sugar and white flour, play a major part in the origin of cancer of the bowel and colon. Geographic variations in the incidence of breast cancer also have been correlated with fat content of diets.

Another notable difference between the diet of the Western World and that of developing countries is the proportion of unabsorbable fiber. The fiber content of diet affects the time food takes to travel through the intestines, the bulk and consistency of stools and the bacterial population of the colon. The low residue diets of Westerners increase the time the food is retained in the colon and prolong the opportunity for colon bacteria to convert dietary materials, such as steroids, to cancer-causing compounds. Studies thus far have provided convincing evidence that diet is important in many respects other than in meeting nutritional requirements. As research continues, we will probably become increasingly aware of the relationship between diet and disease, especially cancer.

Recommendations

Diets associated with low incidences of various forms of cancer have several features in common. However, it should be remembered that none of these factors is absolute. Many nutrients, when present in sufficient amounts, enhance the body's defenses against disease but, when in short supply, decrease this defense. These nutrients, which are well dispersed in a variety of foods, include protein, vitamins and minerals. The incidence of cancer could be reduced by developing the general eating habits, incorporating these nutrients which are described here. Be sure to eat a well-balanced selection of foods which are nutritionally adequate. Avoid prolonged cooking and excessive use of salt, condiments and nutritionally empty foods such as sugar and alcohol. Since excessive use of refined sugar may replace other foods in your diet, it will reduce the intake of nutrients. Refined sugar, of all common foods, uniquely supplies only calories with no protein, fats, vitamins or minerals.

The most nutritious protein foods are obtained largely from animal and some plant sources. We must be careful, however, to consume only small amounts of animal fats. To do this effectively and still receive adequate protein, keep processed meats, such as ham, lunch meat and wieners, to a minimum. Substitute defatted animal protein, such as roast beef and skinned chicken or fish in moderation. Excellent sources of animal protein besides meat, fish and fowl include eggs, hard cheese and cottage cheese and milk (including buttermilk, skim milk and yogurt). Include a high percentage of bulk in your diet by eating whole grain cereals, salads, raw fruits and vegetables with the peelings, unsweetened stewed fruits and bran. Fresh, uncooked seasonal fruits and vegetables should be eaten daily. Citrus fruit, in addition to juice, should definitely be included. Vegetables of the deep yellow and dark green varieties are excellent. A variety of these, occasionally including the potato and its peeling, should be eaten daily either cooked or raw. They should never be fried or served with high fat condiments, such as butter or sour cream. Be sure to wash the surface of all fresh fruits and vegetables carefully to reduce the intake of pesticides. However, never soak them and dry the surfaces after washing to prevent nutrient loss. The general rule to follow to get optimum nutrients from fruits and vegetables is that fresh varieties are best. Many canned and stewed fruits are undesirable because of sweetening with refined sugar.

To these general suggestions, add a daily multiple vitamin supplement and adequate daily fluid intake consisting of fresh fruit juices (purchase only varieties to which sugar has not been added or prepare your own fresh fruit juice and drink without sweetening), tomato juice, skimmed milk or cultured buttermilk and water. Keep coffee and tea to a minimum.

Your dining environment also may be very important. Appetite and flow of digestive juices can be greatly enhanced by preparing colorful and flavorful meals. Also, a relaxed, peaceful atmosphere with soft conversation promotes healthy digestion. Any disruptive influences such as excessive noise, distracting TV programs or family arguments actually promote gastrointestinal disturbances. These points cannot be overemphasized since no meal, no matter how nutritious, is of any value if not eaten or digested properly.

Your entire behavioral pattern can affect the development of cancer. Many environmental factors are now recognized as cancer-causing. Each individual can make behavioral choices to avoid cancer or he can ignore the facts and possibly expose himself to potential cancer-causing factors. Diet has been discussed in detail. Listed below are some other suggestions which could affect the development or nondevelopment of cancer in the individual:

1. Adjust your daily caloric intake according to your work habits and body build to avoid excess body weight (Table 1). (Correlations have been shown between obesity and cancer, as well as heart disease.)
2. Get a good, sound natural sleep every night.
3. Avoid use of tobacco in any form. The correlation between lung and oral cancers and tobacco has been strongly established, and tobacco has been implicated as causative of other cancers.
4. Practice good oral hygiene including regular examinations by a dentist.
5. Avoid prolonged exposure to direct sunlight. If you work in the sun, wear protective clothing including a hat with a brim and gloves. Prolonged exposure to direct sunlight has been directly linked to skin cancer.
6. Practice good genital hygiene. Increasing evidence suggests that child-bearing at a very early age slightly increases the chance for developing cervix cancer. All women who started their families early in life should, more than any other group, have examinations and Pap smears of their wombs regularly.
7. Avoid chemical carcinogens in any form when possible. Some carcinogens and precarcinogens in foods were mentioned earlier. However, many other chemicals are in the environment and have been identified as cancer-

TABLE 1

DESIRABLE WEIGHTS FOR MEN AND WOMEN

According to Height and Frame—Age 25 and Over

Height (With Shoes) FEET	INCHES	*Small Frame*	*Medium Frame*	*Large Frame*
Men				
Weight in Pounds (in indoor clothing; for nude weight deduct 5-7 lbs)				
5	2	112-120	118-129	126-141
5	3	115-123	121-133	129-144
5	4	118-126	124-136	132-148
5	5	121-129	127-139	135-152
5	6	124-133	130-143	138-156
5	7	128-137	134-147	142-161
5	8	132-141	138-152	147-166
5	9	136-145	142-156	151-170
5	10	140-150	146-160	155-174
5	11	144-154	150-165	159-179
6	0	148-158	154-170	164-184
6	1	152-162	158-175	168-189
6	2	156-167	162-180	173-194
6	3	160-171	167-185	178-199
6	4	164-175	172-190	182-202
Women				
Weight in Pounds (in indoor clothing; for nude weight deduct 2-4 lbs)				
4	10	92- 98	96-107	101-119
4	11	94-101	98-110	106-122
5	0	96-104	101-113	109-125
5	1	99-107	104-116	112-128
5	2	102-110	107-119	115-131
5	3	105-113	110-122	118-134
5	4	108-116	113-126	121-138
5	5	111-119	116-130	125-142
5	6	114-123	120-135	129-146
5	7	118-127	124-139	133-150
5	8	122-131	128-143	137-154
5	9	126-135	132-147	141-158
5	10	130-140	136-151	145-163
5	11	134-144	140-155	149-169
6	0	138-148	144-159	153-173

Excerpted with permission from: *Pocket Book of Medical Tables,* published by Smith Kline & French Laboratories, SK&F Services Department, 1500 Spring Garden Street, Philadelphia, Pennsylvania 19101.

causing agents. Control of carcinogenic contamination of the environment, however, is no longer a matter of individual choice. Reducing the significance of this problem will take federal, state and community action. Financial and political support for the control efforts of agencies monitoring the carcinogenic composition of man's environment is necessary from everyone.

None of the above, including a proper diet, can eliminate cancer. However, if the scientist's observations and numerous isolated reports are correct, people could theoretically reduce their chances of getting cancer by the lifelong practice of the dietary and behavioral habits suggested.

One of the most important approaches to the correction of bad habits is through the retraining of one's tastes and interests. One of the first questions many people ask is "what's left to do and eat?" The answer is that there are more interesting things to do and good things to eat than you have ever tried before if you will open your eyes and mind to them.

In addition, you should have a prompt examination if any of the following symptoms develop between your periodic DETECT examinations:

1. Unusual bleeding or discharge.
2. A lump or thickening in the breast or elsewhere.
3. A sore that does not heal.
4. Change in bowel or bladder habits.
5. Hoarseness or cough.
6. Indigestion or difficulty in swallowing.
7. Change in a wart or mole.

If your signal lasts longer than two weeks, go to your doctor to have the symptom evaluated. The best chance for effective treatment is available to those whose cancers are found while still asymptomatic through regular DETECT examinations.

If any of the suggestions contained in this article are different from instructions you have from your physician, consult your physician before you change, since other medical problems may require approaches other than those suggested here.

If you have any questions, write or have your doctor write to the Cancer Research Center, Business 70 and Garth Ave., Columbia, Mo. 65201.

Addendum: A supplemental reading list will be published in the reprints of this article.

Scientific Sessions Important to Every Physician!

116th MSMA ANNUAL SESSION

April 4-7, 1974 Kansas City Crown Center Hotel

FRANCIS R. WATSON, Ph.D., ***Columbia***

Missouri Cancer Registry

Incidence of various types of cancers and the extent of morbidity and mortality due to each must be known to properly plan cancer control measures in any population. The Missouri Cancer Registry is involved in analyzing these data to provide information important for cancer control planning in Missouri and to further enhance knowledge about the epidemiology of cancer. Dr. Watson is from the Department of Biomathematics, Cancer Research Center.

Disease registries are becoming ever more important in maintaining the health of the people. This is particularly true as greater emphasis is being placed on preventive medicine. An advanced society needs knowledge concerning the incidence and prevalence of diseases in order to assess the morbidity and mortality in the people due to given diseases.

This information is of vital importance in order to be able to reduce the deleterious effect of the disease on the people. Action against a disease may be taken at different stages. The most desirable stage, of course, is the prevention of the occurrence of the disease. But, prevention demands that the epidemiology and the causative factors of the disease are well understood. The epidemiological knowledge can be obtained only through the establishment of a central registry wherein all occurrences of the disease, along with relevant information, are recorded and analyzed to yield patterns which are capable of indicating, if not the causative factors themselves, then, at least, what action may be taken to reduce the incidence of the disease. Indeed, the causes of many diseases were discovered only through such epidemiological studies.

In order to properly plan cancer control measures in any population, the incidence of the various types of cancers must be known as well as the extent that morbidity and mortality are due to each. These indices tell the responsible authorities and the medical community in which areas action is most vitally needed.

Because cancer is a complex and chronic disease, it is important to continually monitor changing epidemiological trends.

For these reasons, the state of Missouri has contracted with the Cancer Research Center in Columbia to organize a statewide cancer registry for the ultimate purpose of epidemiological studies and to assist in the cancer control effort. The Missouri Cancer Registry is considered to be but one section in the State Center for Health Statistics. As such, it does and will continue to work and cooperate with all other sections of the Center and all areas of the Division of Health in the exchange of information and expertise.

The Missouri Cancer Registry operated on a planning contract from April 1 to Sept. 30, 1972, and on an operational grant since Oct. 1, 1972. It is, of course, impossible to set up a mechanism to receive complete reporting of all cancer cases in the state of Missouri within the time the registry has been operational. However, ten hospitals are now reporting information on all their cancer cases to the Missouri Cancer Registry. This represents, perhaps, about 25% of all cancer cases in Missouri. We feel that demonstrates excellent cooperation among those who are concerned about furthering our knowledge about cancer in Missouri.

The mechanism of the registry is now sufficiently organized to receive information from more hospitals. Therefore, other hospitals wishing to enter the Missouri Cancer Registry at the present time are invited to make inquiry.

At the present time, those hospitals sending information to the Missouri Cancer Registry are employing the forms which they had previously been using. This, of course, creates extra work within the registry since all must eventually be converted to a common set of information and format. In order to alleviate this problem, a new form has been developed which contains information common to all present forms and which, it is hoped, may be satisfactorily employed by all hospitals in the registry in the near future. This form has received the approval of the American College of Surgeons for use in accredited hospital tumor registries.

A second major problem hindering the more rapid development of the Missouri Cancer Registry is that of the various coding schemes em-

(Continued on page 27)

CLIFFORD W. RICHTER, Ph.D. *and*
ALEXANDER P. TURNER, Ph.D., ***Columbia***

Medical Physics' Support to the Modern Physician

Medical physics research is broad and includes almost every area of medicine. This paper describes the responsibility of the medical physicist and the ways in which he is involved in modern medicine. The authors are from the Department of Physics, Ellis Fischel State Cancer Hospital. This work was supported in part by Clinical Cancer Training Grant CA-08018 from the National Cancer Institute.

The medical physicist is a scientist in modern medicine. He is primarily concerned with the application of ionizing radiation to medical diagnosis and therapy. He also is generally responsible for radiation safety and usually serves as the institution's radiation safety officer.

It has been estimated by Shalek[1] that about 20% of radiation therapy treatments given in clinical trials deviated by more than 5% from the prescribed dose. Some of the doses varied from a 21% overdose to less than 27% of giving the prescribed dose. The seriousness lies in that an error of 7% may be noted clinically and may be sufficient to influence the outcome of treatment.

A first step in overcoming this problem is the exacting calibrations of treatment machines. Here the physicist uses instruments that have been intercompared with other institutions and calibrated by federal laboratories. This insures consistency of dose among institutions that is necessary so various treatment schemes can be compared and the results analyzed. Physicists are generally available to consult with other physicists or institutions that do not have physicists to insure quality fulfillment of prescribed dose.

A second step in the fulfillment of dose prescription is achieved by physicist-radiotherapist interactions. Here, the physicist gives valuable paramedical reinforcement which can directly affect the quality of patient care.

The physicist does calculations relating to specific patients so that the prescribed dose of radiation is given at the tumor site. These calculations may be done either by hand or by computer. The first step of the computer calculation is to enter the contour of the patient into the computer and define a tumor volume. When a beam is placed on the contour, various depth dose data are displayed and a proper beam and entrance angle can be selected. When the therapist is satisfied with the treatment plan, the computer will define the angle, field size, percent depth dose and other parameters needed to set up the patient. This is then printed out to become a portion of the patient record.

The most common type of hand calculation is the Clarkson calculation. These are performed on patients with irregularly shaped fields. The purpose of these calculations is to determine the dose at various points off axis in the field. This type of calculation is especially useful in the treatment of lymphomas. The treatment plan may specify a uniform dose to several nodal areas. But because of the irregularity of the patient's contour and the depth of these nodal areas, a uniform dose will not be achieved through conventional portals. If this occurs, the disease may remain and recur. With Clarkson calculations, areas of lower dose can be defined and supplemental boost can be given. This will achieve a uniform dose across the area. This method of using an anterior mantle field and boosting nodal areas of low dose with posterior field has led to an increase in cure rate for this type of disease.

Physicists also are actively engaged in the development of highly specialized types of radiation machines. This includes the high-energy linear accelerator and betatron. These machines are designed to give high-energy x-ray beams from several MeV to about 40 MeV that better maximizes the dose to the tumor and minimizes the dose to normal tissue for certain types of cancer. These machines also produce electron beams covering approximately the same energy range. These beams are used to treat areas near the surface and spare underlying areas.

The high-energy linear accelerator demands extensive shielding requirements and newly developed, highly specialized dosimetry techniques to calibrate the beams. These new efforts require constantly improving techniques in the measurement of radiation to insure proper patient dose.

In the area of nuclear medicine, the medical physicist works with the physician in exploring new diagnostic procedures. To check to see if the dose to the patient is acceptable for the procedure, the physicist will calculate the dose to various organs and systems in the body. This may be verified with in vivo dosimetry systems. The procedures are tested with animals before human use until these factors are known.

Diagnostic and therapeutic radiation machines and sources require periodic checking of both the machines and the area to see if they meet state and federal requirements for safety. This includes checking machine operation and monitoring the area around the machines and sources to see if the radiation levels are safe. The physicist also aids with shielding and room design in the construction phases of new facilities and additions to existing facilities.

As radiation safety officer, the physicist assesses and controls radiation hazards and monitors the exposure to persons around therapy and diagnostic radiation machines and sources as well as radioisotope laboratories. He also insures compliance with state and federal agencies regulating the usage of radiation. Part of this task is to leak test all sealed sources to insure they have not been ruptured and are safe for use.

Medical physics research is broad and includes nearly every area of medicine. In addition to the services already discussed, the physicist is also involved in the medical use of ultrasound and infrared, medical electronics, thermography, bioengineering, health physics and the teaching of medical physics and some aspects of biophysics and radiobiology.

REFERENCE

1. Shalek, R. J.: Cooperative Medical Physics: Texas Regional Program. Cancer Bull. 24:52, May/June 1972.

Missouri Cancer Registry

(Continued from page 25)

ployed by the different hospitals within the state. The general medical coding scheme employed by the Division of Health is the H-ICDA. It would be convenient, therefore, to have the summary of all data made according to this classification. In order to accomplish this, however, it is necessary to create tables to convert codes from each of the other classification methods to the H-ICDA. This development has been initiated within the registry, but will require considerable effort to complete. The medical coding schemes now under consideration for conversion to H-ICDA are: SNOP—Standard Nomenclature of Pathology, and, SNDO—Standard Nomenclature of Diseases and Operations.

QUALITY OF DATA

The Missouri Cancer Registry is working toward the goal of obtaining complete and uniform information concerning the morbidity and mortality due to cancer in the state. As this desideratum is approached, methods will be developed to assure the quality of this data. Presently, it is felt that one of the best ways to accomplish this is to return to the submitting hospital a listing of all the records sent in during a given time interval. In this way, the registry secretary at the hospital may review the activity in that hospital over that time period and catch some obvious gross errors which may have occurred. It has been found that these listings have been useful to many registry secretaries for other purposes as well.

Within the registry, the submitted data are partially inspected by a medical coder to minimize accidental errors which may have occurred. If the coder cannot definitively correct the error, it is referred back to the hospital registry for correction. Within the computer programming, there also exist further checks on the data which are entered to assure their reasonableness. The problem of the quality of data is very important and special procedures are being continually developed and implemented as the registry develops.

Presently, data from two major sources of the extent of cancer in Missouri are being analyzed to the extent possible. One of these sources is the ICEPICK data which is a survey of hospital discharges. However, not all hospitals are covered in this survey with the consequence that a complete picture of cancer in the state cannot be developed from this source.

Another major source of data concerning cancer in Missouri is death certificates. Each death certificate contains the ICDA-8 code for the primary cause of death as well as other demographic data, such as sex, age at death and other information.

The registry is involved in analyzing these data to obtain cancer death rates and absolute counts for various geographic and demographic subgroups. This information will be important for cancer control planning and further enhancing our knowledge about the epidemiology of cancer.

DOROTHY L. RODGERS, M.D., ***Columbia****

The Cancer Detection Clinic

Progress Report

Emphasizing the importance of recording a thorough, cancer-oriented history and a physical examination of asymptomatic patients, the Cancer DETECTion Clinic of the Cancer Research Center in Columbia opened in February, 1972. The Clinic consists of the following ten rooms in the northwest corner of the Research building: reception room, two examining rooms with connecting lavatory, doctor's office, nurses' station, two x-ray rooms, a dark room and an area for showing educational films.

The detection routine is as follows:

After determination of his or her understanding of the services, a brochure entitled "Your Cancer Detection Examination" and a history questionnaire form are sent to the prospective patient. The brochure outlines the differences between detection, diagnosis and prevention of cancer. It also gives optimum scheduling suggestions for mammography, Pap Testing and the preparations requested for blood studies and proctoscopy. (Mammography is done when the female patient is five to 14 days past onset of menses or is off hormone medications; Pap testing is done just before menses, preferably.)

At present, the history questionnaire form is in two parts; much of it was set up by Dr. Galen Cook.[1, 2] The form includes 674 possible answers to questions with boxes in which to set off more serious symptom areas for easy noting of "yes" responses to denote abnormalities and a concentration on social, genetic and occupational theoretical predisposing factors. The history, which is completed by the patient at home, is evaluated by the physician prior to his seeing the patient.

The examination is designed to assure a high possibility for detecting cancer in the most common, accessible sites: skin, lung, colon-rectum, prostate, breasts, pelvic organs, mouth, throat and lymph system. The nurse checks the patient's vital signs, height and weight. She also draws blood for the complete blood cell count and the SMA-12 and examines the urine. PA and lateral chest x-rays are done on all patients. Six to eight views of the breasts are taken in nonpregnant women over 40 years of age. In younger women, x-rays are done only if indicated by breast problems or findings. Abnormal findings are recorded diagrammatically and descriptively on detailed forms designed to reduce the amount of writing necessary.

During their waiting periods or after the examination, the patients or relatives or both are shown short films on breast self-examination, fears of proctoscopy and physiologic effects of smoking or cessation of smoking. A critical evaluation of the examination and facilities by the patients is requested.

The blood studies are done by a local, private laboratory. The x-rays and Pap smears are interpreted at Ellis Fischel State Cancer Hospital. Patients are told the results of their tests, and a report is sent to any physician they designate. No treatment is given at the Clinic since abnormal findings are to be treated by the patient's own physician. Physicians who have referred patients for mammography alone receive the report. Most patients are Missouri residents, many of whom have had friends or relatives who were patients at Ellis Fischel State Cancer Hospital.

In 1972, 55 patients had the complete examination at the Clinic and four patients had mammography alone. One previously undiagnosed cancer which was found was a basal cell carcinoma of the skin of the shoulder, and the patient was treated by a local dermatologist. Four patients who had had cancer treated elsewhere were examined. No evidence of recurrence was found.

Other positive diagnoses made at the Clinic included arteriosclerotic heart disease, hypertension, obesity, gout, enlarged thyroid, esophagitis, myomata, cervical polyps, vulvar leukoplakia, prostatic nodule and actinic keratoses. Abnormal laboratory studies showed anemia, leukopenia and elevated serum glutamic oxaloacetic transaminase (SGOT), lactic dehydrogenase (LDH), blood urea nitrogen (BUN) and uric acid. The number of patients seen to date is too small to establish statistical values.

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* Dr. Rodgers is Examining Physician at the Cancer Detection Clinic, Cancer Research Center.

Tours of the Clinic and discussions of the facilities and the examination have been conducted for several groups of visiting nurses, civic organizations and students. The educational films have been used in talks to local groups at their requests.

In addition to providing continuing education about cancer and its prevention, future plans for the Detection Clinic include incorporating new detection ideas and laboratory studies as soon as they are feasible.

References

1. Cook, G. B.: Direct Patient Retrieval of Cancer Risk Data. Mo. Med. 65:975, Dec. 1968.
2. Cook, G. B.: Toward Modernization of Medical Documents, Cancer Bull. 21:18, Jan.-Feb. 1969.

Continuing Education Coming Events

Jan. 25-26	**The Long Weekend: Immunology, Hematology** University of Missouri-Kansas City and Kansas City Southwest Clinical Society Crown Center Hotel, Kansas City
Jan. 31-Feb. 1	**Symposium: Diagnostic Cytology** Postgraduate Medical Education, K. U. School of Medicine Kansas City, Kan.
Feb. 6	**Seminar: Early Detection and Treatment of Carcinoma of The Breast** The Ed Bixby Institute for Postgraduate Medical Education Research Hospital and Medical Center Kansas City

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Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

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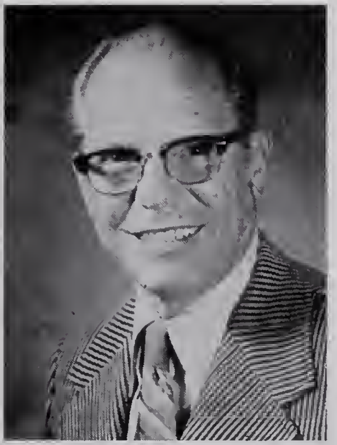
1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

President's Message

Now that the Clinical Convention of the AMA held at Anaheim, Calif. is over, we can add the various bits together to see what was accomplished.

Of the many deliberations considered at the meeting, the controversial PSRO law was in the limelight. About 30 physicians presented emotional and heated testimony. Every speaker had a different viewpoint, which ranged from fight for repeal of the law, lobby for amendments and try to make the best of the law by implementation to refusing to participate in any development of PSRO.



E. A. Stricker, M.D.

Of the various options, the amendments to the law seemed to be the most acceptable. Nonparticipation by the profession would invite government intervention, and a flat policy for repeal was thought by some to be an exercise in futility.

One of the PSRO-related issues was the confidentiality of patient medical information. Many doctors fear the pervasive "invasion of the right to privacy of all citizens," this right being threatened by computerized collection of personal data.

National health insurance and health maintenance organizations received major attention. Congressman Hastings of New York, a member of the House Health Sub-Committee, said that "we should start improving the primary delivery system before we start worrying about quality of care." He and others on the panel inferred that HMOs were the answer. He also informed us that of the $375 million appropriated by Congress for initiation of HMOs, none would be used for the consumer or patient. (Is it any wonder that the cost of health care is so high? Several doctors commented acidly that health problems cannot be solved by throwing money into new programs.)

Dr. Charles C. Edwards, Assistant Secretary for Health, HEW, commended the AMA for its leadership in coming forward with a national health insurance proposal, one which is receiving serious consideration by the Congress and the Executive Branch.

There was much static about Phase IV economic controls. Mr. John Kaufman, chairman of the American Hospital Association's Board of Trustees, made an appeal for AMA to join AHA in the fight against fee controls. AMA has had a problem getting a sympathetic ear with the Cost of Living Council—being reminded by the Council that physicians still have the highest income in the nation.

Medical students and house staff were better organized and in larger numbers at this meeting and took an active part in all discussions.

The House of Delegates approved a resolution sanctioning "death with dignity"—not "mercy killing," but the right *not* to use artificial life-sustaining measures on a dying patient.

Don't forget that your Missouri delegates and officers maintain a hospitality room at every AMA meeting in the headquarters hotel for your convenience in meeting and visiting with other Missourians and, also, for meeting and entertaining other state delegations and exchanging unofficial views with them.

Woman's Auxiliary

50th Anniversary

This Is the Golden Year

Auxiliary members are looking forward to an exciting year in 1974 as we move toward the beginning of our *50th Anniversary Year* in April. This is our *Golden Year* and we are emphasizing our theme, "Building for the future on the heritage of the past."

Mrs. Charles R. Willman
President

Since the "building" is the responsibility of the individual members of the Woman's Auxiliary to the MSMA, it seems appropriate to quote a statement made by Anne Lindberg in her book, "Gift From the Sea":

> "To be a woman is to have interests and duties raying out in all directions—the pattern of our lives is circular. We must be open to all points of the compass—husband, children, friends, home, community."

The doctor and his wife must desire to be well-rounded individuals . . . must accept change and responsibility in this changing world. They must be sympathetic to the needs of others and direct their own talents to aiding programs and promoting better health care. They must be members of a forward-looking organization, such as the Missouri State Medical Association or its Auxiliary. They must be willing to use new ideas. They must volunteer to help make the wheels spin easily and involve other organizations in their voluntary actions if it seems a more adequate way to accomplish the goal.

For a better year in 1974, please consider the following suggestions:

This year, I'll mend a quarrel,
Seek out a forgotten friend.

Dismiss suspicion and replace it with trust.
Give a soft answer. Encourage youth.

Manifest my loyalty in word and deed.
Keep a promise.

Find the time. Forego a grudge. Forgive an enemy.
Listen. Apologize, if I'm wrong.

Try to understand,
Examine my demands on others.

Think first of someone else. Appreciate.
Be Kind. Be Gentle.

Laugh a little . . . laugh a little more.
Reserve confidence. Express my gratitude.

Go to church. Welcome a stranger.
Gladden the heart of a child.

Take pleasure in the beauty and
The wonder of the earth.

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

The annual meeting and installation of officers of the Buchanan County Medical Society were held for physicians and their wives at the St. Joseph Country Club on December 5. Dr. Elza F. Butler, retiring President, presided and served as installing officer.

Dr. Randal W. Weed, radiologist, was installed as President; Dr. William B. O'Connor as President-Elect; Dr. G. Tyson Carpenter as Vice-President; and Dr. John T. Rogers as Secretary. Dr. Robert W. Kieber, Treasurer, started his 21st consecutive term in this office.

Dr. Clement C. DuMont was named to the Board of Censors and Dr. Allen I. Herman was elected as a Delegate to the Missouri State Medical Association. Alternate Delegates are Drs. R. Philip Acuff, William B. Rost and Donald J. Stallard.

Dr. John N. Martin serves on the Committee on Public Policy, Dr. Carl K. Ness as Trustee to 1979 and Dr. Butler as a member of the Executive Secretary Committee.

Arrangements for the event were made by the Society's Program Committee of which Dr. Gerald E. Fox is Chairman and Dr. Edward M. Beheler and Dr. Edward H. Andres are members.

John T. Rogers, M.D., *Secretary*

SEVENTH DISTRICT

COUNCILOR
R. ALLEN CHANDLER, KANSAS CITY

Jackson County Medical Society

Dr. Warren F. Wilhelm of Kansas City has been elected President-Elect of Jackson County Medical Society for 1974. President for the coming year is Dr. Fred D. Fowler.

At the election meeting, Dr. William D. Hoadley was elected to the Judicial Board of the Society. Members also selected four new members of the Executive Council which formulates policies and programs. New Councilors are Drs. Richardson K. Noback, Ronald A. Youmans, Federico Adler and Calvin E. Engelmann. All were elected for three-year terms.

Drs. Bailey C. Andrus, Lawrence Evans and William J. Medlicott were elected as members of the Medical Business Bureau Advisory Committee.

Delegates to the Missouri State Medical Association who were elected in the annual balloting are Drs. Alfred D. Biggs, Jr., Calvin E. Engelmann, Braham J. Geha, R. Stacy Long, Mark D. Ost, Milton B. Ozar and John M. Singleton, III.

Alternate Delegates to the MSMA are Drs. George P. Williams, Thomas J. Fritzlen, Vance Link, Robert W. Doering, J. A. Sheahon, Earl G. Padfield, Herbert Waxman, D. J. Cutcliff and Sidney Pakula.

Coronary Prevention Trial—Physicians' Help Needed

The medical profession of the St. Louis area is being asked to help resolve the cholesterol-coronary question. It is well known that people with high serum cholesterol levels are at high risk for developing coronary artery disease. The important question is *can "coronaries" be prevented by lowering the serum cholesterol?*

Patients are needed to help settle this important question. Physicians can help by referring patients with high cholesterol levels to Washington University Lipid Research Center in St. Louis.

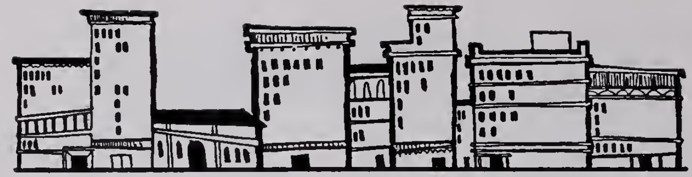
The criteria for referral are as follows:

Elevated cholesterol
Men, aged 35-39 years
No manifest coronary artery disease

Patients will remain under the primary care of their own physicians; the doctor-patient relationship will be scrupulously respected; there will be no cost to patients for any tests or drugs.

Call Drs. Schonfeld or Witztum at 314-454-3162 or write to the Lipid Research Center, Washington University School of Medicine, Box 8046, 4566 Scott Ave., St. Louis, Mo. 63110.

From the Medical Schools



UNIVERSITY OF MISSOURI-COLUMBIA

Dr. James M. A. Weiss, professor and chairman of the Department of Psychiatry, and *Dr. David Davis,* professor of psychiatry and associate chairman, recently returned from an international meeting of the Royal College of Psychiatrists held at the Royal Society of Medicine in London. Theme of the meeting was "Postgraduate Psychiatric Training with Special Reference to Foreign Graduates." Dr. Weiss and Dr. Davis were the only American psychiatrists invited to present papers and serve on the discussion panels.

Drs. Weiss and Davis reported on research studies conducted at the University of Missouri-Columbia to develop methods for predicting success for American and foreign medical graduates in psychiatric specialty training.

Dr. Weiss also presented an invited lecture on American postgraduate educational methods in the mental health sciences at the 850-year-old St. Bartholomew's Hospital Medical School in London.

A comprehensive set of instructional materials for loan to medical laboratory personnel is expected to be available by mid-January. The inservice continuing education program is offered by the Pathology Department at the University of Missouri Medical Center.

Practically any phase of clinical laboratory work may be studied through slides, audio-tapes, films and written hand-outs. The basic areas covered include cytology, blood banking, serology, urinalysis, clinical chemistry, coagulation, hematology, microbiology and other areas of pathology.

A more detailed description of the available programs may be obtained by writing to Clinical Laboratory Media Center (Attention, Terry Clapp), Department of Pathology, University of Missouri Medical Center, Columbia, Mo. 65201. There is no charge for the service.

WASHINGTON UNIVERSITY

Washington University School of Medicine's Executive Faculty has approved the formation of a joint Department of Neurology and Neurological Surgery effective July 1, 1974. The increasing number of mutual interests of these disciplines has prompted this action.

Sidney Goldring, M.D., professor of Neurological Surgery, has been appointed head of Neurological Surgery and cohead of the new department with *William M. Landau,* M.D., professor of neurology and head of the present Department of Neurology.

Dr. Goldring replaces *Henry G. Schwartz,* M.D., August A. Busch, Jr. professor of Neurological Surgery, who is retiring as head of Neurological Surgery. Dr. Schwartz will continue with his important teaching functions and in the practice of neurological surgery.

Dr. Goldring received his M.D. degree from Washington University in 1947, and had his residency training in neurosurgery at Barnes Hospital. He was a member of the Washington University Medical Faculty from 1956 to 1964 when he left to become Chairman of the Division of Neurosurgery at the University of Pittsburgh Health Center Hospitals, including Presbyterian University, Children's, Veterans Administration and Eye and Ear Hospitals. In 1966, he rejoined the Washington University faculty as Professor of Neurological Surgery.

Dr. Goldring is respected for his extensive research on brain function, especially as it relates to epilepsy, and for his work with computers in mapping the minute electrical impulses of the human brain.

Cohead of the new department, Dr. Landau, is a native St. Louisan who attended the University of Chicago for undergraduate study, and received the M.D. degree cum laude from Washington University School of Medicine in 1947.

In 1970, he succeeded *James L. O'Leary,* Ph.D., M.D., as Head of the Department of Neurology.

A member of the medical faculty since 1952, Dr. Landau did his graduate training at the University of Chicago Clinics, St. Louis City Hospital, Washington University and the National Institutes of Health.

ST. LOUIS UNIVERSITY

Dr. Harry W. Schoenberg, professor and director of urology at the School of Medicine, and *Dr. John C. Gregory,* assistant professor of urology, recently were presented a SONY color videocasette system and seven videocasettes which cover 22 medical and surgical subjects. The gift from Eaton Laboratories was given on a loan basis to the department.

Dr. Schoenberg said the color videocasette system will enhance the teaching program for residents, interns and medical students who can study the teaching films on their own in a laboratory at the St. Louis University Hospitals. He said Eaton Laboratories will provide additional videocasettes in the future. The presentation ceremony was attended by Eaton representatives, residents in urology and *Mr. Richard L. Stensrud,* director of the St. Louis University Hospitals.

Dr. D. Elliott O'Reilly, professor of orthopedic surgery and chairman of the Department, took office as president of the American Academy for Cerebral Palsy at its meeting in Washington, D.C. on December 2-6. *Dr. Otakar Machek,* assistant clinical professor of physical medicine and rehabilitation in internal medicine, was moderator of a panel session at the meeting.

Dr. Thomas F. Frawley, professor of internal medicine, participated in the Governors Conference of the American College of Physicians in Montreal, Canada. He is the Governor of the American College of Physicians for Missouri. Dr. Frawley and *Dr. Francis Zacharewicz,* assistant professor of medicine, participated in a Diabetes Symposium on December 7 at Stouffer's Riverfront Inn. Dr. Frawley spoke on *Hypoglycemia, Its Diagnosis and Management.* Dr. Zacharewicz discussed *Preparation and Criteria for Diagnosis of Diabetes Melitus.*

Three Alumni Memorial Lectures, which were established under the leadership of *Dr. Robert D. Mattis* in the Department of Ophthalmology, were held on November 30. The annual Milton R. Israel Memorial Lecture titled "Opportunistic Lesions in the Eye" was delivered by *Dr. Morton E. Smith,* associate professor of ophthalmology and associate professor of pathology, Washington University School of Medicine. The Thomas E. Andert Memorial Lecture on "Contact Lenses —Hard or Soft" was delivered by *Dr. Robert J. Fleming,* senior instructor in ophthalmology at the School of Medicine. The William F. Luedde Memorial Lecture titled "Marchesani's Syndrome and Its Management" was delivered by *Dr. Robert R. Trotter,* professor of surgery and chairman, Division of Ophthalmology, West Virginia University.

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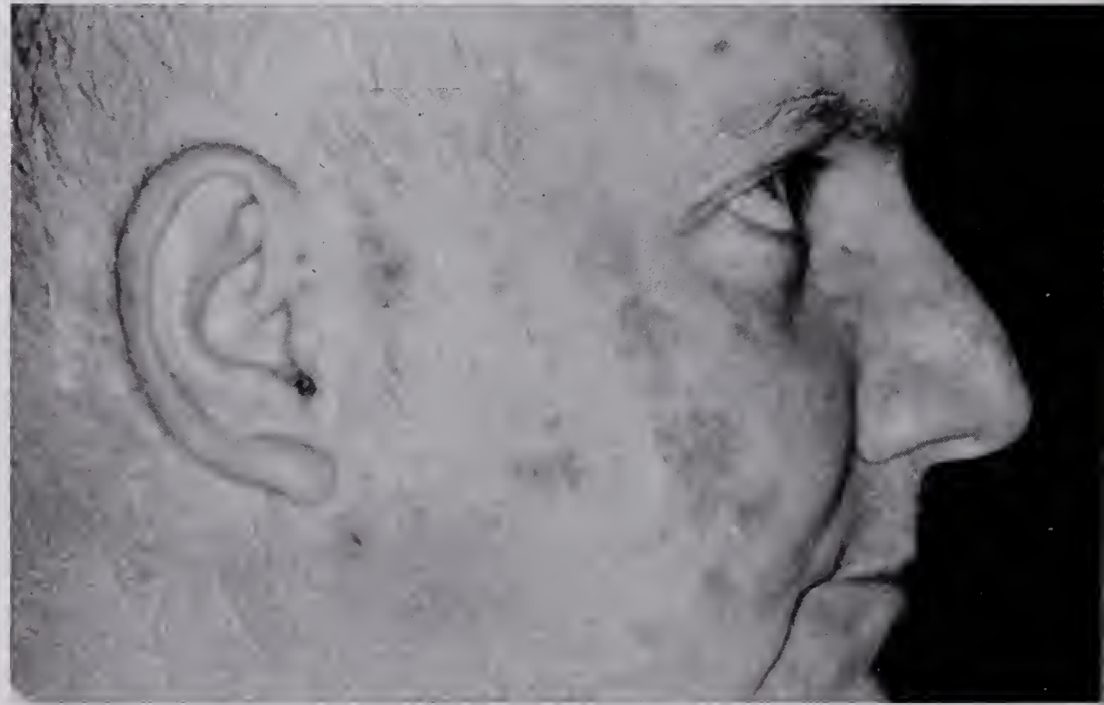
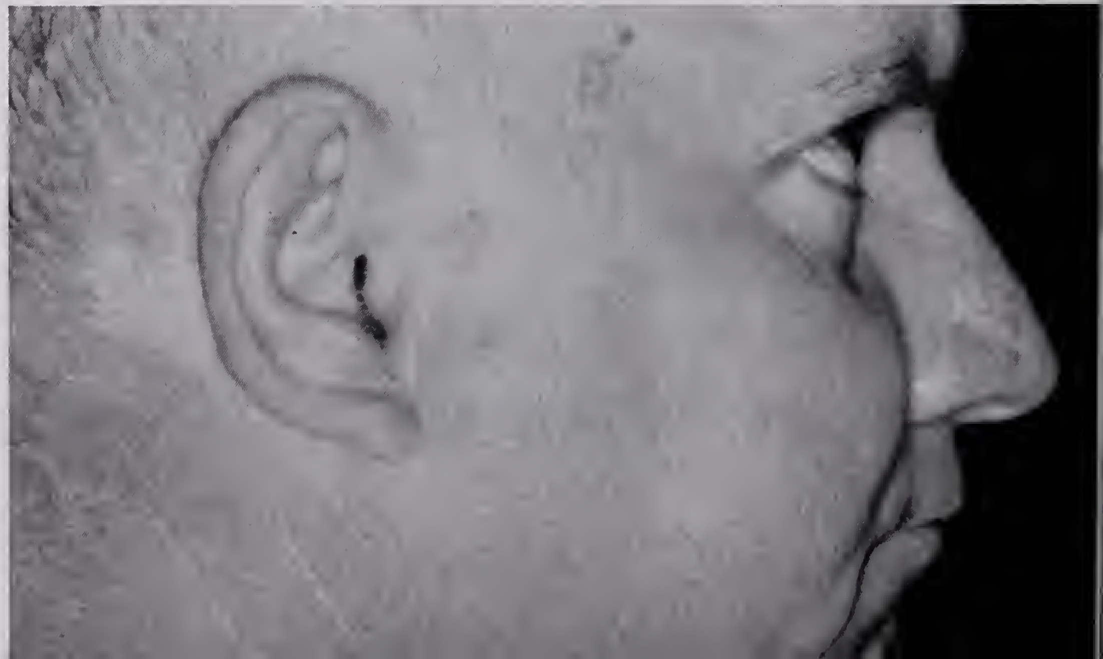
What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.



*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face re solar/actinic— o-called “senile” keratoses... nd they may be premalignant.

olar, actinic or senile keratoses

ese lesions may be called by several names, but they
ually can be identified by the following characteris-
s. The typical lesion is flat or slightly elevated, of a
wnish or reddish color, papular, dry, rough, adherent
d sharply defined. They commonly occur as multiple
ions, chiefly on the exposed portions of the skin.

equence of therapy— electivity of response

ter several days of therapy with Efudex® (fluorouracil),
thema may begin to appear in the area of the lesions;
s reaction usually reaches its height of unsightliness
d discomfort within two weeks, declining after dis-
ntinuation of therapy. This reaction occurs in affected
as. Since the response is so predictable, lesions that
not respond should be biopsied.

cceptable results

atment with Efudex provides highly favorable cos-
tic results. Incidence of scarring is low. This is par-
ularly important with multiple facial lesions. Efudex
uld be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

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Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

This patient’s lesions were resolved with Efudex® fluorouracil/Roche®

5% cream/solution...a Roche exclusive

New Members

Andres Alisuag, Jr., M.D., 2850 W. Clay, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Alisuag is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1967. He specializes in internal medicine and cardiology.

John T. Ashley, M.D., 24th and Cherry, Kansas City, has become a member of Jackson County Medical Society. Dr. Ashley is a native of Boston, Mass., received his preliminary education at the University of Missouri-Columbia and his M.D. degree at the University of Missouri-Columbia in 1970. He specializes in medical administration.

William L. Bayer, M.D., 4040 Main, Kansas City, has become a member of Jackson County Medical Society. Dr. Bayer is a native of New York, N. Y., received his preliminary education at Colgate University and his M.D. degree at Albany Medical College in 1962. He specializes in hematology.

David M. Berwald, M.D., 11789 Natural Bridge, Bridgeton, has become a member of St. Louis County Medical Society. Dr. Berwald is a native of St. Louis, received his preliminary education at the University of Cincinnati and his M.D. degree at St. Louis University in 1966. He specializes in general surgery.

Lanny Ross Brent, M.D., 1504 N. Robberson, Springfield, has become a member of Greene County Medical Society. Dr. Brent is a native of Alton, Kan., received his preliminary education at Kansas State University and his M.D. degree at the University of Kansas in 1965. He specializes in radiology.

Shih-Chung Chang, M.D., 7221 Anna, Maplewood, has become a member of St. Louis County Medical Society. Dr. Chang is a native of Taiwan, received his preliminary education at Tapci Medical College and his M.D. degree at Crung-Shan Medical College in 1968. He specializes in obstetrics and gynecology.

James H. Chapman, M.D., 4801 Linwood, Kansas City, has become a member of Jackson County Medical Society. Dr. Chapman is a native of Omaha, Neb., received his preliminary education at the University of Nebraska and his M.D. degree at the University of Tennessee in 1963. He specializes in radiology.

Steven H. T. Chua, M.D., 1125 Graham Rd., Florissant, has become a member of St. Louis County Medical Society. Dr. Chua is a native of Manila, Philippines, received his preliminary education at Far Eastern University and his M.D. degree at Far Eastern University in 1967. He specializes in internal medicine and cardiology.

John W. Collins, M.D., 1734 East 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Collins is a native of Laural, Miss., received his preliminary education at Tuskegee Institute and his M.D. degree at Meharry Medical College in 1966. He specializes in orthopedic surgery.

C. Wesley Cooper, M.D., 1211 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Cooper is a native of Memphis, Tenn., received his preliminary education at Vanderbilt University and his M.D. degree at Vanderbilt University in 1965. He specializes in internal medicine.

Ed L. Crostwait, M.D., 1305 Battlefield, Springfield, has become a member of Greene County Medical Society. Dr. Crostwait is a native of Jackson, Miss., received his preliminary education at Memphis State University and his M.D. degree at the University of Tennessee in 1969. He specializes in general practice.

John Marvin Edison, M.D., 600 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Edison is a native of Cedar Rapids, Ia., received his preliminary education at Brown University and his M.D. degree at the University of Iowa in 1964. He specializes in otolaryngology.

Harry C. Eggleston, M.D., 11201 Ladue Rd., St. Louis, has become a member of St. Louis County Medical Society. Dr. Eggleston is a native of Kansas City, received his preliminary education at St. Louis University and his M.D. degree at Creighton University in 1966. He specializes in ophthalmology.

Ahmed A. El'Toumi, M.D., 4500 W. Pine, St. Louis, has become a member of St. Louis County Medical Society. Dr. El'Toumi is a native of Cairo, Egypt and received his M.D. degree at Cairo Medical School in 1952. He specializes in psychiatry.

Franklin B. Farrales, M.D., 4040 Main, Kansas City, has become a member of Jackson County Medical Society. Dr. Farrales is a native of Zambales, Philippines, received his preliminary education at the University of the Philippines and his M.D. degree at the University of the Philippines in 1963. He specializes in pathology.

Eliseo O. Figueroa, M.D., 1175 Appleseed Lane, St. Louis, has become a member of St. Louis County Medical Society. Dr. Figueroa is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1968. He specializes in internal medicine.

Walter J. Gaska, M.D., 1211 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Gaska is a native of Binghamton, N. Y., received his preliminary education at Lemoyne College and his M.D. degree at the University of New York in 1964. He specializes in plastic surgery.

Royal D. Goerz, M.D., 1612 W. Truman Rd., Independence, has become a member of Jackson County Medical Society. Dr. Goerz is a native of Marion, S. D., received his preliminary education at the University of South Dakota and his M.D. degree at Tulane University Medical School in 1964. He specializes in obstetrics and gynecology.

George B. Grim, M.D., 1650 Boonslick, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Grim is a native of Kirksville, received his preliminary education at the University of Dubuque, Iowa and his M.D. degree at the University of Missouri-Columbia in 1962. He specializes in ophthalmology.

Man Mohan Gursahani, M.D., 1040 N. Mason Rd., Creve Coeur, has become a member of St. Louis County Medical Society. Dr. Gursahani is a native of India, received his preliminary education at M. R. College in India, and his M.D. degree at S. M. S. Medical School in India, in 1964. He specializes in urology.

Sara T. Jones, M.D., 801 S. Brentwood, St. Louis, has become a member of St. Louis County Medical Society. Dr. Jones is a native of Greensboro, N. C., received her preliminary education at Women's College of the University of North Carolina and her M.D. degree at Bowman Gray School of Medicine in 1962. She specializes in anesthesiology.

Hartmut Kannegiesser, M.D., 300 S. Grand, St. Louis, has become a member of St. Louis County Medical Society. Dr. Kannegiesser is a native of Zwickau, Germany and received his M.D. degree at the University of Mainz in 1964. He specializes in internal medicine.

Chandra S. Kaup, M.D., 2012 Westfield, St. Louis, has become a member of St. Louis County Medical Society. Dr. Kaup is a native of India, received his preliminary education at M.G.M. College and his M.D. degree at Government Medical College in 1965. He specializes in internal medicine.

Hea Ill Kim, M.D., 6334 N. Wood, St. Louis, has become a member of St. Louis County Medical Society. Dr. Kim is a native of Korea, received his preliminary education at Yonsei University and his M.D. degree at Yonsei University in 1962. He specializes in general surgery.

Robert J. Kingsbury, M.D., 222 South 2nd, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Kingsbury is a native of Sagamore, Mich., received his preliminary education at Asbury College and his M.D. degree at the University of Michigan in 1960. He specializes in general surgery.

Henry C. Krahn, M.D., 1423 N. Jefferson, Springfield, has become a member of Greene County Medical Society. Dr. Krahn is a native of Gretna, Manitoba, received his preliminary education at the University of Manitoba and his M.D. degree at the University of Manitoba in 1957. He specializes in radiology.

Howard E. Linder, M.D., 3015 N. Ballas Rd., St. Louis, has become a member of St. Louis County Medical Society. Dr. Linder is a native of New Vienna, Ohio, received his preliminary education at Asbury College and his M.D. degree at the University of Cincinnati in 1965. He specializes in pulmonary medicine.

Sherwin Hugh Malt, M.D., 777 S. New Ballas Rd., Creve Coeur, has become a member of St. Louis County Medical Society. Dr. Malt is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at the University of Missouri-Columbia in 1966. He specializes in general surgery.

Delfin T. Nieva, M.D., 5291 Brass Lantern, St. Louis, has become a member of St. Louis County Medical Society. Dr. Nieva is a native of the Philippines, received his preliminary education at the University of the Philippines and his M.D. degree at the University of the Philippines in 1967. He specializes in anesthesiology.

John F. Rose, M.D., 1024 Grandview, Chillicothe, has become a member of Grand River Medical Society. Dr. Rose is a native of Kansas City, received his preliminary education at the University of Missouri-Columbia and his M.D. degree at Tulane Medical College in 1966. He specializes in diagnostic radiology.

Fawzi Soliman, M.D., 3015 N. Ballas, St. Louis, has become a member of St. Louis County Medical Society. Dr. Soliman is a native of Egypt, received his preliminary education at the Faculty of Science and his M.D. degree at Cairo University in 1963. He specializes in general surgery.

Steven J. Soper, M.D., 1505 W. Truman Rd., Independence, has become a member of Jackson County Medical Society. Dr. Soper is a native of Independence, received his preliminary education at the University of Missouri-Kansas City and his M.D. degree at the University of Kansas in 1967. He specializes in psychiatry.

Dan T. Sullivan, M.D., 609 Cherry, Springfield, has become a member of Greene County Medical Society. Dr. Sullivan is a native of Okemal, Okla., received his preliminary education at Central State College and his M.D. degree at the University of Oklahoma in 1962. He specializes in diagnostic radiology.

Loren F. Taylor, M.D., 44th and Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Taylor is a native of Lafayette, Ind., received his preliminary education at Indiana University and his M.D. degree at Indiana University in 1955. He specializes in legal medicine and anesthesia.

Jonas S. Tejero, M.D., 515 Jefferson, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Tejero is a native of Bangued, Abra, Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1953. He specializes in general internal medicine.

Richard A. Waldman, M.D., 24th and Gillham Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Waldman is a native of New York, received his preliminary education at Morse Institute of Technology and his M.D. degree at New York University in 1968. He specializes in pediatrics.

Donald K. Wantuck, M.D., 1211 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Wantuck is a native of Springfield, received his preliminary education at the University of Missouri-Columbia and his M.D. degree at the University of Missouri-Columbia in 1964. He specializes in internal medicine.

Harold D. West, M.D., 1734 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. West is a native of Nashville, Tenn., received his preliminary education at Tennessee A. and E. and his M.D degree at Meharry Medical College in 1964. He specializes in orthopedic surgery.

Bruce I. White, M.D., 4910 Forest Park, St. Louis, has become a member of St. Louis County Medical Society. Dr. White is a native of Kansas City, received his preliminary education at Beloit College and his M.D. degree at Washington University in 1964. He specializes in plastic surgery.

In Memoriam

Frank P. McNalley, M.D., 8019 Watkins Dr., St. Louis, a graduate of Washington University, 1917; member of St. Louis County Medical Society; age 80; died Oct. 24, 1973.

John H. Duemler, M.D., 5321 Sunshine Dr., St. Louis, a graduate of St. Louis University, 1924; member of St. Louis Medical Society; age 75; died Nov. 4, 1973.

Arthur N. Altringer, M.D., 5630 Mission Dr., Shawnee Mission, Kan; a graduate of the University Medical College of Kansas City, 1913; member of Jackson County Medical Society; age 82; died Nov. 10, 1973.

Lyle G. Willits, M.D., 1224 West 62, Kansas City, a graduate of Northwestern University in 1921; member of Jackson County Medical Society; age 76; died Nov. 18, 1973.

Bobby M. McLain, M.D., P.O. Box 447, Poplar Bluff, a graduate of the University of Texas,' 1954; member of Butler-Wayne-Ripley County Medical Society; age 48; died Nov. 20, 1973.

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

Raphael Isaacs, Cyrus C. Sturgis, S. Milton Goldhamer and Frank H. Bethell of Ann Arbor, Mich. gave 1,000 intravenous injections of liver extract to 140 patients with pernicious anemia (*Journal of the AMA*, March 4, 1933). Intravenous injections of the extract made from 100 gm to 125 gm of liver may be given weekly to patients with pernicious anemia until the red blood cell count is normal and then once every month as a maintenance dose. A characteristic "reticulocyte response" is induced by this type of therapy, but the average maximum percentage is higher than that reached after about 40 times as much material as is usually taken by mouth in divided doses daily.

T. L. Althausen, San Francisco, points out that the presence of a certain amount of glycogen is essential for the proper functioning of the liver. The human body at rest requires 30 calories or 8 gm of dextrose per kilogram of weight (*Journal of the AMA*, April 15, 1933).

On December 7-8, about 40 members of the Kansas City Society of Ophthalmology and Otolaryngology met in St. Louis as guests of the St. Louis University Medical School, Washington University Medical School and St. Louis Ophthalmology Club. The first day was spent at St. Louis University where an instructive program of operations, lectures and demonstrations was given.

TWENTY-FIVE YEARS AGO

Physicians: (a) Of Missouri's 3,073 physicians in private practice (1946), 125 were non-white; 710 (about one fourth) practiced in isolated semirural and rural counties. Of the latter number, 444 (nearly two thirds) were more than 55 years old. Only seven of the state's 75 pediatricians had offices outside the metropolitan areas. (b) Pediatricians: The ratio of children per pediatrician (1946) was 12,854. Of the 75 pediatricians, 42 had been certified by the American Board of Pediatrics; 68 had their offices in metropolitan areas. (c) *Training:* Twenty-three percent of the general practitioners reporting said that they had received no hospital training; 58% reported that they had received either no hospital training in pediatrics or for less than one month. It must be remembered that a large proportion of the general practitioners were in the age group to which such training was rarely available. Dentists: (a) In July, 1946, there were 2,043 dentists in private practice in Missouri. Fifty-three of these were nonwhite. For the whole state, there was a ratio of 472 children per dentist. Twelve states had lower ratios, as did three of the five selected neighboring states. In Missouri's metropolitan counties, the ratio was about 300 children per dentist; in rural areas, about 1,000 per dentist. (b) *Training:* Of 735 dental practitioners reporting, only 33 had received any postgraduate training in pedodontics.

TEN YEARS AGO

Hearings started on Monday, November 18 before the House Ways and Means Committee on the King-Anderson bill, HR 3920, and other legislative proposals involving medical-hospital care for the elderly. Originally scheduled to continue through Wednesday, November 27, the hearings were recessed due to the death of the late President John F. Kennedy. Latest information indicates that Mr. Wilbur Mills, chairman, will reconvene the hearings sometime after Jan. 1, 1964.

The Jackson County Medical Society held a Recognition Dinner on November 20 for Mr. William H. Bartleson on the occasion of his 25 years as an executive official with the Society.

The St. Louis Pediatric Society has installed Dr. James K. Turner as president for the 1963-1964 term. Other officers elected were Dr. Francis X. Lieb, president-elect, and Dr. Helen M. Aff-Drum, secretary-treasurer.

Acknowledgement: Dr. Pollock wishes to express appreciation to the Medical Library of the University of Missouri-Kansas City School of Medicine for making available the various references used in preparing this column.

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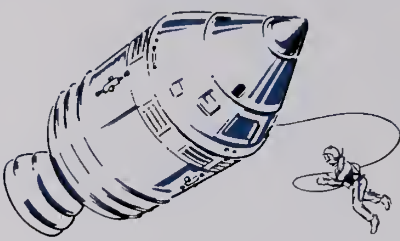

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Illustrations should be glossy prints or drawings in India ink on white paper. They should not be mounted and name of author and figure number should be penciled lightly on the backs. Legends should appear on a separate sheet. Colored illustrations will be used when suitable if author assumes the actual cost.

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MSMA NEWS ROUND-UP

FEBRUARY, 1974

Pre-certification, area PSRO's

AMA threatens suit against HEW

The AMA has served notice that it will take Secretary of Health, Education and Welfare Casper Weinberger to court if HEW proceeds with implementation of proposed hospital pre-admission certification and PSRO area designations.

Russell B. Roth, M.D., AMA President, told a press conference in Chicago on Jan. 25 that HEW's proposed pre-certification regulation is a direct threat to the 35 million Medicare and Medicaid patients in the U.S. and that the proposal is in violation of the Medicare-Medicaid laws.

The proposed regulations would require that all Medicare and Medicaid patients be cleared by a hospital Utilization Review Committee before the patient could be admitted to a hospital.

This could very well result in a patient being denied hospital admission not on the basis of a physician's examination, but by a "paper decision" from the patient's record, Roth stated.

In many cases, Roth continued, the decision to admit or not admit a patient would not be made by a physician, but by an admitting nurse.

Roth said the AMA will seek help from other interested organizations such as senior citizens groups but added, the AMA will seek an injunction in this matter the same day they go into effect.

Roth then tossed out AMA's challenge to the PSRO area designations announced by HEW in December.

Roth said that although the AMA originally opposed PSRO's, after PSRO became law, the AMA attempted to cooperate with HEW in order to draft regulations which represented the private physician's point of view.

However, Roth continued, the cooperation has been mostly one-way with little in return from HEW.

Therefore, the AMA Board of Trustees has voted to join with any state medical organization which desires to take HEW to court over PSRO area designations. Roth indicated that 7 or 8 states had expressed interest in challenging the designations.

MSMA Council informs lawmakers of PSRO stand

Members of Missouri's Congressional Delegation were recently informed of the stand taken by the Council of MSMA regarding PSRO's in a letter from R. Allen Chandler, M.D., Chairman of the Council.

Dr. Chandler's letter included the motion on PSRO's adopted by the Council and welcomed comments from the Senators and Representatives concerning PSRO.

The motion adopted by the Council reads:

"The Council of the Missouri State Medical Association believes that the PSRO law (Sec. 249F, PL 92-603) should be repealed or effectively amended and we will work actively with the Missouri Congressional Delegation to this end."

National health insurance hearings held in state

Hearings on national health insurance were held Feb. 1-2 in St. Louis and Kansas City by the U.S. House Health Subcommittee, chaired by Rep. James W. Symington, St. Louis.

Richard V. Bradley, M.D., President of the St. Louis Medical Society, testified before the subcommittee as did other representatives of medicine, labor unions and citizens groups.

Among the issues discussed were:

1. Are there too few doctors? Are resource deficiencies responsible for current defects in the U.S. medical system?
2. Is there a maldistribution of health professionals and individual specialties? How can rural and underserved urban areas be better served medically?
3. Who lacks access to preventive care? Is improved health education a proper substitute for increased health insurance coverage supported by tax dollars?
4. Are home health agencies underutilized? What are the probable effects of HMO's?
5. What are the dangers to patient-physician relationship? Does national health insurance threaten the private practitioner?

Annual Session to feature new site

An exciting new meeting-experience is in store for the record number of physicians who are expected to attend the 116th Annual Session of the Missouri State Medical Association on April 4-7 in Kansas City at the new Crown Center Hotel.

Probably the most unusual hotel to open anywhere in the world in 1973, the Crown Center Hotel features a five-story limestone cliff inside the lobby. It is terraced into a tropical garden with brook and waterfall, bringing the outdoors indoors.

The hotel has 730 big rooms with 730 balconies which provide each room with a view of Kansas City. It also sports 21 meeting rooms, a ballroom that seats 1,600 for a banquet or 2,200 for a meeting, three restaurants, five bars and features of a resort, such as tennis courts, a putting green, a year-round pool and a health club.

The hotel is the ideal setting for the 1974 meetings of the MSMA House of Delegates, 25 scientific sessions, medical exhibits and luncheons and banquets.

Highlights of the meeting will include the Past-Presidents' Banquet on Saturday, April 6, when James C. Cope, M.D., Columbia, will be installed as President. Past-Presidents of the Association and members of the 50-Year Club also will be honored.

Awards will be presented to medical writers who are winners in the Missouri State Medical Association news competition for 1973. Tickets for the banquet and other events will be on sale at the MSMA Registration Desk in the hotel.

The scientific sessions this year will offer a wide choice of programs on a variety of topics. Some of these continuing medical education programs will be sponsored by specialty organizations, some of whom will hold their annual meetings in conjunction with the MSMA.

The preliminary program for the 1974 Annual Session and scientific programs appears on pages 53-55 of this issue of *Missouri Medicine.*

Included in the scientific sessions will be subjects relating to trauma and emergency care services, prehospital coronary care, allergies, pediatrics, gastrointestinal diseases, urology, psychiatry, surgery, cardiovascular diseases, radiology, tumor immunology, dermatology, pulmonary diseases and metabolic diseases.

Scientific sessions are scheduled all day Friday and Saturday, April 5-6.

Speakers at the General Session at 9 a.m. Friday will be John M. Chenault, M.D., member of the AMA Board of Trustees, and Holman R. Wherritt, M.D., Regional Health Administrator for Region VII, Department of Health, Education and Welfare, Kansas City. Their topic will be Professional Standards Review Organization (PSRO).

Every member of the MSMA is urged to attend a new and innovative meeting titled "Speak Out to Your AMA Delegates" which is scheduled for 9:30 a.m. Saturday. Missouri's AMA Delegates and Alternates will be there for an open forum-type discussion for all members regarding positions and opinions on AMA-related subjects.

Guest speaker at the MSMA General Luncheon at 12:30 p.m. Saturday will be the Honorable William J. Cason of Clinton, president pro-tem of the Missouri Senate.

The MSMA House of Delegates will meet a 1:30 p.m. on Thursday, April 4; 4 p.m. on Friday April 5; and 7:30 a.m. on Sunday, April 7.

Auxiliary to celebrate 50 years of service

The Woman's Auxiliary to the MSMA will celebrate its 50th Anniversary at the 1974 Annual Meeting, which will be held in conjunction with the MSMA Annual Session.

Mrs. Charles R. Willman of St. Joseph, President, reports that the highlight of the two-day meeting will be the Anniversary and Installation Luncheon on Saturday in the Crown Center Hotel.

In observation of the anniversary, the Auxiliary has compiled and published in book form the history of the Woman's Auxiliary to the Missouri State Medical Association. It is titled "50 Years of Service" and will be on sale at a nominal cost at the registration desk and luncheon.

Mrs. Willman invites all physicians' wives who will be in Kansas City to visit the Auxiliary's registration desk and join in the gala birthday celebration.

Delegates to consider Constitutional amendments

Delegates to the 116th Annual Session will vote on tw Constitutional amendments.

The first amendment amends Article IX of the Constitution to read as follows:

"Petition signed by 10% of the active members of th Association, including petitioners representing at lea one-half of the component Medical Societies, will initiat a referendum regarding changes in the Constitution an Bylaws or questions before the House of Delegates. two-thirds vote of all active members of the Associatio responding will determine the question."

The second amendment amends Article IV of the Constitution by inserting a comma following the word "Association" and adding the following words, "the Speake and Vice Speaker." This sentence would then read:

"The House of Delegates shall be the legislative boa of this Association and shall consist of delegates electe by the component societies as well as all Past-Presiden of the Association, the Speaker and Vice-Speaker, wh shall serve as delegates-at-large.

Bills! Bills! Bills!

Legislature 'long' on medically-related measures

For what is termed the "short" Session, the recently reconvened Missouri General Assembly s already "long" on medically-related bills.

As of Jan. 25, 71 House bills and 15 Senate bills have been tagged by the MSMA as measures to watch — some with active support or opposition and others with a "wait and see what develops" attitude. And, bills are still being introduced each day.

In just two weeks of legislative action, three MSMA-supported bills have cleared committees with "Do Pass" recommendations. Floor action on the bills should be soon. The three bills are:

*Senate Bill 336 (Physical Therapist Regulations) strengthens present law by prohibiting a person not licensed as a physical therapist from representing himself as a physical therapist.

*Senate Bill 341 (Delegation Amendment) places into the statutes that a physician's trained assistant, R.N. or LPN can provide certain medical assistance to patients if such assistance is rendered under the direct and personal supervision, control and responsibility of a licensed physician.

***House Bill 1328 (Sick Doctor) is designed to provide that the State Board of Healing Arts can require a sick physician to meet certain criteria in able to continue practice.**

The bill is designed to protect the public and to salvage sick physicians by offering them an opportunity to receive mental or physical help before their license is revoked.

Two additional MSMA-supported bills are due for hearings.

House Bill 1487 (Insurance for Newborns) provides that all individual and group health insurance policies must offer coverage for newborns from birth. Senate Bill 561 (Laboratory Licensing) would license and regulate commercial clinical laboratories in the state. Bill would not affect private physician's lab facilities.

Several unfavorable bills have been introduced o date.

House Bill 972 (Acupuncture) sets up licensing for acupuncturists, but contains no provision that acupuncture is within the practice of medicine. Upon recommendation of the MSMA, the bill has been referred to a subcommittee for study.

House Bill 1334 (Chiropractic-By Hand) would remove the restriction from the chiropractic law which provides that adjusting of the spine must be done "by hand" and, therefore, would expand the practice of chiropractic.

House Bill 971 (Professional Physical Therapist) reduces the requirements for physical therapists and would open the door for chiropractors to enter the field.

Several bills which had not been introduced when the MSMA Council last met, will be studied for possible support or opposition when the Council meets in February.

House Bill 1401 (Drugs-Generic Name) would require physicians to include the generic name with the brand name on all prescriptions. Pharmacies would be required to post a list of brand name drugs with the generic equivalents and a price list.

House Bill 1127 (Crippled Children's Service) provides that when CCS accepts a child for any service, it would provide all services for complete care and rehabilitation. No child could be released from CCS without approval of parents or guardian.

Other bills introduced would repeal the Ambulance Law enacted in 1973; create a Commission to study rural health care needs; place certain limits on abortions; establish a state Authority with the power to issue notes and bonds to finance construction of health facilities; and prohibit licensing boards from denying a license primarily on the basis of a felony conviction.

Many, many other bills are already in the hopper and will be detailed in later issues of *Missouri Medicine.*

Quick now! Who is your State Senator?

Who is your State Senator?

Perhaps that is a simple question for some. But for many other MSMA members who have not followed the political trail closely, the names of their State Senator, Representative or even Congressman might be unfamiliar. And, with politicians passing laws almost daily which affect the practice of medicine, it is becoming imperative that all physicians and their wives know their lawmakers.

The 1973-74 "Missouri Legislative Directory" is available to all MSMA members at no cost by writing MSMA Headquarters, 113 Madison St., Box 1028, Jefferson City, Mo. 65101.

The "Directory" lists the name, district and address of Members of Congress from Missouri and all State Senators and State Representatives.

Drop a postcard in the mail today to receive a copy. After you learn who your lawmakers are, get to know them.

****News of interest to physicians****

Phase 4 pamphlet available

Two informational pamphlets of interest to physicians are available at no cost to MSMA members.

"A Physician's Guide to Phase 4" of the Economic Stabilization Program has been prepared by the AMA. The pamphlet details Phase 4 regulations and provides assistance for the computation of accumulated allowable fee increases, the cost of justification test and revenue margin calculations. It is available from the Center for Health Service Research, AMA Headquarters, 535 N. Dearborn St., Chicago, Ill. 60610.

The MSMA recently received a quantity of pamphlets outlining requirements for the AMA's "Physician Recognition Award." To obtain a copy, write to MSMA Headquarters, Box 1028, Jefferson City, Mo. 65101.

* * * * *

MSMA membership increases

Membership figures for 1973 show an increase for both the MSMA and AMA.

As of Dec. 31, 1973, MSMA membership had risen to 4,468, an increase of 41 members of the Dec. 31, 1972 total.

Missouri physicians who are paid members of the AMA increased by 90 last year to a total of 3,292. The AMA awarded the MSMA special recognition for increased membership.

* * * * *

"Policy Manual" planned

Research is under way for material needed to establish a "Policy Manual" for the MSMA.

The Manual will list the positions taken by the MSMA House of Delegates and Council on subjects of concern to medicine.

When completed, the Manual will be furnished to all MSMA members for referral.

* * * * *

"Physician for a Day"

The MSMA is again cooperating with the Missouri Academy of Family Physicians in the "Physician for a Day" program at the Missouri General Assembly.

Members of the Academy volunteer to serve as "Physician for the Day." Along with the obvious service they provide, the physicians have an excellent opportunity to meet and talk with their elected representatives and many other influential members of the General Assembly and the Administration.

* * * * *

Remember those Resolutions!

MSMA members and County Societies are again reminded that February 18 is the deadline for insertion of Resolutions in the Delegates' Handbook for the 1974 Annual Session.

A copy of Resolutions should be mailed to MSMA Headquarters.

* * * * *

Mitchell to head CHP

William C. Mitchell, Jefferson City, has been named new director of the Missouri Comprehensive Health Planning Agency.

Mitchell, former director of Missouri Association for Mental Health, succeeds Edward J. Peloquin, who announced his resignation effective Feb. 1.

* * * * *

"MMPAC Workshop" postponed

The "MMPAC Workshop," scheduled for Feb. 1 in Jefferson City, was postponed due to insufficient response from MSMA members.

The Workshop program, location and timing will be reconsidered and, it is hoped, the Workshop can be rescheduled late this year.

* * * * *

Sign posting required

MSMA members are reminded that under Phase 4 guidelines issued by the Cost o Living Council, physicians are required t post an easily readible sign stating the availability of the physician's price schedule.

One page of the MSMA News insert i the December issue of MISSOURI MEDICINE was designed to serve as such a sign The December issue also carried an articl dealing with other requirements under Phas 4.

* * * * *

Dr. W. A. Bloom dies

William A. Bloom, M.D., of Fayette, a form President of the Missouri State Medical Associ tion, died Dec. 22, 1973, at the age of 75.

Dr. Bloom, the senior member of the staff Central Methodist College, Fayette, was active organized medicine for many years. He served President of the MSMA in 1950.

* * * * *

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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

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See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3',5'-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic endproducts do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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MISSOURI STATE MEDICAL ASSOCIATION

Crown Center Hotel, Kansas City **April 4-7, 1974**

Thursday, April 4

11:00 AM Registration of Delegates.
1:30 PM House of Delegates Meeting, opening session.
3:30 PM Reference Committee Meetings.
6:30 PM Missouri State Surgical Society Executive Council Meeting, Buttonwood Tree Inn, 4800 Main.

Friday, April 5

8:00 AM Registration.
9:00 AM General Session. *Professional Standards Review Organization (PSRO).*
Introduction: E. A. Stricker, M.D., St. James, MSMA President.
Speakers:
John M. Chenault, M.D., Member, Board of Trustees, American Medical Association.
Holman R. Wherritt, M.D., Regional Health Administrator, Region VII, Department of Health, Education and Welfare, Kansas City.
10:30 AM Intermission to view exhibits.
10:30 AM Presiding: Clarence C. Cohrs, M.D., Moberly, President, Missouri State Allergy Association.
Participants:
Association Between Learning Disorders, Behavior Disorders and Allergy, James Hartwright, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
The Antigenic Deterioration Rate of Aqueous Ragweed Pollen Extracts, Josephine G. Brunidor, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
The Dual-Based System of Immunity, Norman T. Berlinger, M.D., New York, N. Y., Fellow, Clinical Immunology Service, Memorial Hospital and Research Associate, Sloan-Kettering Institute for Cancer Research.
The Immunologic Aspects of the Allergic Reaction, Daniel J. Stechschulte, M.D., Kansas City, Kan., Chairman, Section of Allergy and Immunology, University of Kansas Medical Center.
Electron Microscopy of Aphthous Stomatitis, Philip Carr Anderson, M.D., Columbia, Chairman and Professor, Dermatology and Allergy, University of Missouri-Columbia School of Medicine.
Rapid Determination of T-Cell Presence in Premature and Newborn Infants, Ronald Moyer, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
Sponsored by Missouri State Allergy Association.
[*]11:00 AM *Common Pediatric Gastrointestinal Problems.*
Giulio J. Barbero, M.D., Columbia, Professor and Chairman, Department of Pediatrics, University of Missouri-Columbia School of Medicine and Vice-Chairman, Executive Board of Directors, National Cystic Fibrosis Research Foundation.
Moderator: Robert C. Fairchild, M.D., Kansas City.
Sponsored by Missouri Chapter, American Academy of Pediatrics.
[*]11:00 AM *Gastrointestinal Diseases.*
Participants:
The Use of Endoscopy in Upper GI Bleeding, Burnell Landers, M.D., Gastroenterology, Kansas City.
Indications for and Results of Colonoscopy (What Is Colonoscopy?), Walter Harvey Jacobs, M.D., Gastroenterology, Kansas City.
Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).
[*]11:00 AM *Program on Psychiatry.* Sponsored by Missouri Psychiatric Association.
[*]11:00 AM *Program on Surgery.* Sponsored by Missouri State Surgical Society.
12:30 PM Missouri University Alumni Luncheon.
[*] 2:00 PM Presiding: Jean Chapman, M.D., Cape Girardeau, President-Elect, Missouri State Allergy Association.

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[*] Concurrent Sessions.

Participants:

Pulmonary Hypersensitivity Syndrome, Raymond Slavin, M.D., St. Louis, Professor of Internal Medicine and Director, Section of Allergy and Immunology, St. Louis University School of Medicine.

Contemporary Considerations in Clinical-Immunology, Norman T. Berlinger, M.D., New York, N. Y., Fellow, Clinical Immunology Service, Memorial Hospital and Research Associate, Sloan-Kettering Institute for Cancer Research.

Disodium Cromoglycate in Pediatric Office Practice, Lester Wall, M.D., St. Louis, Assistant Clinical Professor of Pediatrics, St. Louis University School of Medicine.

Thermography in Clinical Allergic Diseases, Laurie Smith, M.D., St. Louis, Fellow, Section of Allergy and Immunology, St. Louis University School of Medicine.

The Concepts of Allergic Treatment Including Hyposensitization and Regulation of Mediator Release, Daniel J. Stechschulte, M.D., Kansas City, Kan., Chairman, Section of Allergy and Immunology, University of Kansas Medical Center.

Question and Answer period.

Sponsored by Missouri State Allergy Association.

* 2:00 PM **Pre-Hospital** Coronary Care, Richard P. Lewis, M.D., Columbus, Ohio, Chairman, Department of Cardiology, Ohio State University.

Natural History of Coronary Artery Disease, David R. McConahay, M.D., Kansas City, Assistant Clinical Professor of Medicine, University of Missouri-Kansas City.

Moderator: Ben D. McCallister, M.D.

Sponsored by Missouri Heart Association, Inc.

* 2:00 PM *Pulmonary Diseases.*

Participants:

Understanding Blood Gases, George S. Devins, M.D., Pulmonary Diseases, Kansas City.

Management of C.O.P.D., Robert A. Raich, M.D., Internal Medicine, Kansas City.

Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).

* 2:00 PM *Program on Psychiatry.* Sponsored by Missouri Psychiatric Association.

* 2:00 PM *Program on Surgery.* Sponsored by Missouri State Surgical Society.

3:30 PM **Intermission to View Exhibits.**

4:00 PM **House of Delegates,** second session.

5:30 PM Missouri State Medical Foundation Annual Meeting.

6:00 PM Reference Committee Meetings.

6:00 PM Dinner Meeting: Missouri State Allergy Association.

6:30 PM Dinner Meeting: Missouri State Surgical Society.

Dinner: Missouri Psychiatric Association. (Time to be announced.)

Saturday, April 6

8:00 AM Registration.

* 9:00 AM **Trauma and Emergency** Care Services.

(Speakers to be announced.)

Sponsored by Missouri Society of Anesthesiologists and Missouri State Surgical Society.

* 9:00 AM *Cardiovascular Diseases I.*

Participants:

Bedside Evaluation of Cardiovascular Function, James E. Crockett, M.D., Cardiovascular Diseases, Kansas City.

Heart Sounds, Carlton L. Shmock, M.D., Cardiovascular Diseases, Kansas City.

Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Division).

* 9:00 AM Guest Speaker: Miles Galin, M.D., New York City, Professor and Chief, Department of Ophthalmology, New York Medical College.

Sponsored by Missouri Ophthalmological Society, Inc.

* 9:00 AM *Program on Urology.* Sponsored by Federation of Missouri Urologists.

9:30 AM Speak **Out** to Your AMA Delegates.

(Missouri's AMA Delegates and Alternates will be available for an open forum type discussion for all MSMA members regarding positions and opinions on AMA-related subjects.)

10:30 AM **Intermission to View Exhibits.**

10:45 AM Trauma and Emergency Care Services (Continued).

(Speakers to be announced.)

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* Concurrent Sessions.

Sponsored by Missouri Society of Anesthesiologists and Missouri State Surgical Society.

*11:00 AM *Cardiovascular Diseases II.*
Participants:
Medical Management of Acute Myocardial Infarction, Keith H. Averill, M.D., Cardiovascular Diseases, Kansas City.
Surgical Management of Acute Myocardial Infarction, William A. Reed, M.D. and Duncan A. Killen, M.D., Cardiovascular Surgery, Kansas City.
Sponsored by Missouri Society of Internal Medicine and American College of Physicians (Missouri Region).

*11:00 AM *Transmission of Disease by Blood Transfusion.*
William L. Bayer, M.D., Kansas City, Medical Director, Community Blood Center of Kansas City.
Moderator: Thomas J. Fritzlen, M.D., Kansas City.
Sponsored by Missouri Society of Pathologists, Inc.

*11:00 AM *Evaluation and Management of Low Back Disorders.*
Rene Cailliet, M.D., Los Angeles, Calif., Chairman and Professor, Department of Rehabilitation Medicine, University of Southern California.
The Multidisciplinary Approach to the Treatment of Arthritis, Charles R. Peterson, M.D., Columbia, Professor and Chairman, Department of Physical Medicine and Rehabilitation, University of Missouri-Columbia School of Medicine.
The Rehabilitation of the Stroke Patient—When, Where and How, Franz U. Steinberg, M.D., St. Louis, Director, Department of Rehabilitation Medicine, The Jewish Hospital of St. Louis.
Moderator: Franz U. Steinberg, M.D., St. Louis.
Sponsored by Physical Medicine and Rehabilitation.

*11:00 AM *Program on Radiology.* Sponsored by Missouri Radiological Society.

12:30 PM 50-Year Club Luncheon.
Missouri Ophthalmological Society, Inc., Luncheon.
Physiatrics Luncheon.
Missouri State Society of Neurological Surgeons Luncheon.

12:45 PM **MSMA General Luncheon.**
Guest Speaker—William J. Cason, Clinton, President Pro-Tem, Missouri Senate.

* 2:30 PM *Tumor Immunology.*
Moderator: Andrew McCanse, M.D., Kansas City.
Participants:
Basic Science Aspects of Clinical Immunology, Paul Morse, Ph.D., The University of Kansas Medical Center, Kansas City, Kan.
Immunology in the Diagnosis of Malignant Disease, George Pierce, M.D., The University of Kansas Medical Center, Kansas City, Kan.
Immunotherapy of Solid Tumors, William R. Jewell, M.D., The University of Kansas Medical Center, Kansas City, Kan.
Sponsored by American Cancer Society, Missouri Division.

* 2:30 PM *Program on Dermatology.* Sponsored by Missouri Dermatological Society, Inc.

* 2:30 PM *The Family Physician and the Management of ENT Problems.*
Moderator: Lindsay L. Pratt, M.D., St. Louis.
Panel Participants:
Nose Bleeds—Robert Hazen, M.D., Kansas City.
Sinus Disease—Carl Ehrlich, M.D., St. Louis.
Middle Ear Disease—Donald Joseph, M.D., Columbia.
The Dizzy Patient—Malcolm Stroud, M.D., St. Louis.
Maxillofacial Tumors and Injuries—Floyd Barnhill, M.D., Springfield.
Sponsored by Missouri Ear, Nose and Throat Association, Inc.

* 2:30 PM *Metabolic Diseases.*
Participants:
Management of Labile Diabetes, Jerome A. Grunt, M.D., Pediatric Endocrinology, Kansas City.
Diagnosis and Treatment of High Blood Lipids, Ralph R. Hall, M.D., Internal Medicine, Kansas City.
Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).

* 2:30 PM *Program on Radiology.* Sponsored by Missouri Radiological Society.

4:00 PM **Intermission to View Exhibits.**
5:00 PM St. Louis University Medical Alumni Cocktail Party.
5:00 PM Washington University Medical Alumni Cocktail Party.
6:30 PM Social Hour for Those Attending Banquet.
7:15 PM **Annual Banquet in Honor of Past-Presidents.**

Sunday, April 7

7:30 AM **House of Delegates.** Breakfast and Final Session.

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* Concurrent Sessions.

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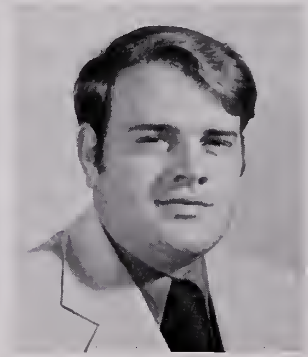
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Special Feature

Rhine Escape Reprise

By

John T. Logue, M.D., Columbia

> *In Namen dieser Reisegruppe mochte ich den Kapitan und seiner Besatzung fur diese Schöne Reise auf dem Rhein bedanken. An dieser Reise werden wir gerne zuruch denken.*
>
> *bei Bär*

THE ABOVE WORDS of appreciation to Capt. Albert Gries and his crew for a wonderful trip up the Rhine River from Rotterdam, Netherlands to Basel, Switzerland were composed by the poets-laureate of our travel group, "Rubin O'Royal," and were translated into German by Berti (Mrs. John T. Logue) during the Captain's dance the last night on board the KD German Rhine Line ship, *France.* For all persons present, these words will always stir wonderful memories of happy times.* For all others, they should ignite a determination not to miss the next postgraduate medical seminar sponsored by the Missouri State Medical Association in that wonderful, sunny land of Greece, the fountainhead of all western civilization.

Every trip should have its unexpected, delightful surprise. So it was when we dropped in with the dawn on Shannon, Ireland for an unanticipated fuel stop. From the formidable headlands facing the nasty North Atlantic to the safe runways at Shannon, Ireland is truly an emerald isle, a never-ending sea of green. While visiting the smiling, happy clerks with their rolling Irish brogues in the tax-free shops at Shannon, it seemed impossible to us that Irish hatreds could be fatally bubbling up not too far to the north. Irish coffee in the early morning does much to subdue such distressing thoughts.

As we flew on toward the booming guns of the latest Mideast war and to our destination in the city of Anne Frank, Amsterdam, Netherlands, one could not help but reflect that we would soon travel along the Rhine River waterway completely devastated by the explosive hatreds of an era just past. Suffice to say that only a few abandoned bridge piers remain as relics of W.W. II, for all the cities bloom anew, the factories spew forth their smoke and pollute the water with oily, watery wastes and nowhere can one see the scars of that war of a few short years ago. That which we Americans helped to destroy has arisen from the ashes like a Phoenix, and everywhere one hears of problems brought about by the massive importation of cheap labor from countries to the south. The anguish of segregation weighs heavily upon the conscience of the industrial countries along the Rhine. The devaluation of the American dollar and an ever-spiralling inflation make European travel a true luxury for Americans, for it is no longer a bargain for us by any measure.

Wonderful, beautiful Amsterdam is a city of canals, bicycles, zooming cars, quaint architecture and industrious people. Therein, one can visit the new Vincent van Gogh museum which houses the world's largest collection by this genius painter who painted only ten short years before taking his life in despair. One can relive this artist's tragic life from the dark days in Nuenen, which he pictured in "The Potato-eaters," to the sun-filled days in Arles in Southern France, which he made forever famous by "The Yellow House," "The Sunflowers" and "Drawbridge at Arles." Or, would one prefer to spend the day strolling through the endless rooms of the Rijksmuseum, which houses an eternity of Dutch Masters' paintings, including the famous "Night Watch" and "The Anatomy Lesson of Professor Joan Deyman" by Rembrandt; my favorite, "The Jolly Toper" by Franz Hals; and a selection of Johannes Vermeer's works which captured the common man doing everyday things invariably highlighted by the streaming sunlight?

Fine restaurants abound in Amsterdam—The Five Flies, and The Bali, famous for rice tafel, curry and chutney, spicy Indonesian fare, or Het Begijntje (The Little Nun), an intimate Dutch restaurant hidden away deep in the old city where exquisite, leisurely dining is enjoyed by those fortunate few finding their way within. Amsterdam's night life stands second to none with amusement enough to

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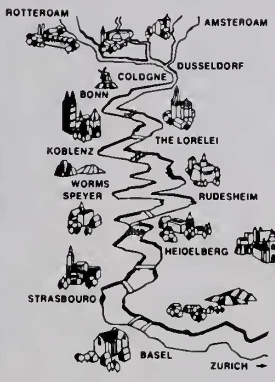
* "In the name of this travel group, I wish to thank the captain and his crew for this wonderful trip on the Rhine. We will remember this trip with fondness."

Where the Rhine swirls around the Lorelei.

A Cruise Into The Heart of Europe



An old Dutch windmill in Amsterdam.

New German bridge and Cologne Cathedral.

Heidelberg, a famous, old university city.

The *France* passes the ancient Marksberg Castle and Brabach, Germany.

satisfy any taste or appetite. Where else can one stroll the streets and window-shop for a companion to fit any specification? One can look for free, but cannot handle the merchandise without paying the fee. Night life is so commercially continental in Amsterdam.

The Netherlands is a small country continually at war with the sea. A never-ending succession of dikes, windmills, water and grassy lands are repetitive scenes from border to sea and from bustling city to deep, quiet pastoral beauty in a few short miles. It is a countryside dotted with beautiful towns and small cities, such as medieval Delft with its world-famed, blue pottery and tile; The Hague and its Peace Palace; Alkmaar with its cheese market; and the famous tulip gardens of Keukenhof. Rotterdam is one of the world's largest, busiest seaports where we all arrived through a chilly mist to begin our ship-born adventures up the Rhine River valley. Rotterdam, whose center was entirely destroyed by fire bombing early in World War II, was the first of many Phoenix-like cities through which we would pass during our southbound journey.

What an impressive sight when one sits at a leisurely breakfast in the spacious dining salon of the Rhein Schiff *France* watching the industrial heartland of Germany pass quickly on either side. The Captain must navigate surely in this stretch of the Rhine swarming with barges bringing coal and ore to the open hearths of the Ruhr Valley. The smoking ruins of World War II are ruins no longer, but now belch endless clouds of smoke-producing steel, the life's blood of an industrial economy. What a welcome relief it was to stroll the beautiful avenues of Düsseldorf, Germany's answer to Fifth Avenue and Nieman-Marcus, on legs unused to the vibrations of ship travel.

For one's dining pleasure, an evening meal in the old city at Bateau Ivre with our native guides, "Friedel" and "Boy," was a never-to-be-forgotten experience in fine eating for the trencherman—salad, saddle of lamb with vegetables, each course served with the proper selection of the finest white wine. Red wines were available in plentiful supply for those who insist that white wine is only for fish and fowl, but along the Rhine, white wine is king and will forever be because the Rhine River and its "little sisters" (the Mosel, the Lahn, the Main, the Nahe and the Neckar) produce white wine in abundance with taste, bouquet and body to please even the most discerning and demanding palates.

From Düsseldorf, it is only a short ride up the river to Cologne, the Queen City of the Rhine, which is dominated by its twin-spired Gothic cathedral alleged to be the resting place of the bones of the three wise men. In recent excavations adjoining the cathedral, a beautiful mosiac dating back to the time of Julius Caesar was uncovered. This mosiac, now open to public view, reminds everyone that Cologne was built on the sites of Roman fortifications along the Rhine, later became a favorite stopping place of Charlemagne and since has been a booming commercial and educational center. Cologne is the mother city of perfume to which she has given her name. For the finest in German fare of soup, schweinebraten and vegetables washed down by glasses full of light German beer in an airy, flower-filled room decorated with Roman artifacts dug up at the site, I heartily recommend Gasthaus Oehmig auf dem Römerberg (on top of the Roman Hill) overlooking the southern Rhine approach to the city. While Berti and I were enjoying this sumptuous meal, the *France* slipped her moorings, passed beneath us on her way upriver to Brabach for the evening's festivities in Marksburg Castle with typical German gemutlichkeit, wursts, steins of hearty German beer, singing and dancing until the wee hours. It was only a short, swift train ride in the pleasant surroundings of the dining car on the Riviera Express to overtake our merry companions in Brabach. The one thing I would gladly import to America is the Rhine countries' system of public transportation. It is swift, efficient, frequent and inexpensive. What would we all have done without street car No. 11 in Amsterdam and Zurich? European trains travelling in all directions arrive and depart on the minute and at very frequent intervals.

We Americans have much to learn about public transportation.

From Brabach to Worms, the Rhine River Valley is a never-ending, eye-pleasing panorama of rugged mountains, forests and hillside vineyards with their quaint villages, each famous as the home of fine wine. Also, one sees large industrial cities usually at the confluence of a tributary river with the Rhine.

Where the Rhine swirls around the soaring Lorelei, one can easily visualize the gods in their Vallhalla, the Valkeries bringing up the dead warriors, the Rhine maidens guarding their Rhine gold and the mortal, struggling heroes torn between good and evil, innocent victims of their gods and the machinations of the netherworld so vividly portrayed in the classic German opera, "The Ring of the Niebelungen," with its thundering, awesome musical score by Richard Wagner. Drawn as it was from ancient German pagan mythology and brought together in heavy prose and an overpowering, thunderous musical score with delicate, recurrent inner themes, this opera reflects in part the recurrent mysticism, romanticism and fatalism of German thinking which has directed the course of the world so much in our lifetime. Who else could settle the bluffs and valleys of the American wilderness bordering our own Missouri River which flows relentlessly toward the mighty Mississippi? Only the Germans could, for it was the refugees from the religious persecutions of the German Reformation in the Rhine Valley who settled our river valleys and are forebearers of many of the Missouri physicians among us.

Indeed, in the midst of this stretch of the Rhine is Rhein Hesse, whose soldiers hired out to King George of England and became forever famous for celebrating Christmas at Trenton, New Jersey while George Washington and his ragtag army crossed the impassable Delaware River while the Hessian soldiers sang "Heilege Nacht." It was from the Rhein Pfalz that America's so called Pennsylvania Dutch" immigrated to southern Pennsylvania to escape the religious persecution of the reformation only to inherit the wrath of Gettysburg in not too long a time.

We were fortunate to view the four red sandstone Romanesque cathedrals along the west bank of the Rhine. We saw Mainz with its five assymetric towers; Speyer with its double twin towers; and Worms, the site of the Diet of Worms. Here in April, 1521, Martin Luther's excommunication from the mother church precipitated the German religious reformation with its succeeding series of devastating wars which swept back and forth throughout the countryside leaving endless burned out castles, palaces and villages as mute historical monuments to the viciousness engendered by those who insisted that all should believe one way or the other. Lastly was the Romanesque Cathedral in Strasbourg, France, most famous for its gigantic circular stained glass rose window whose reflection when the sun is high overwhelms all who are praying far below.

Few among us will forget the leisurely, picturesque travel through the flat vineyards and asparagus flats of the Rhein Pfalz by the Gothic Liebfrauen Kirche, whose name is now used on the most exported Rhein Pfalz white wine, Liebfrauenmilch (milk of our dear Lady). Soon, we passed the cathedral at Worms and drove on up the Neckar River Valley by new nuclear power plants to Heidelberg, a famous, old university city which is the home of the fraternity system, dueling scars and the Roten Oxen Inn, long famed in the operetta "Student Prince." Here all can still enjoy beer drinking and singing, even though Nelson Eddy and Mario Lanza no longer lead all by lifting steins on high while singing "Trink! Trink! Brüderlein Trink!" Kaffe, kuchen, bier und steinhager seemed to be the most popular pick-me-ups for the weary refugees from the cold, late afternoon showers in old Heidelberg. But then, that was long before the evening repast of wurst, kartoffel, sauerkraut und bier at a small, moon-splashed restaurant in Neckargemünd some miles up the Neckar River.

Then came a seemingly never-ending series of Rhine canal locks and a narrower Rhine River with NATO soldiers practicing pontoon bridge building, a reminder of the Suez Canal crossings then going on. We travelled on into Strasbourg, France, a fascinating, modern city with its old, medieval center city surrounding its famous Romanesque cathedral. The unrelenting downpour of rain spattering on the cobblestone streets forced us into a delightful side-alley hideaway, Le Restuarante Au Clou, for pate de foie gras, escargot and quiche lorraine washed down by carafes of the finest French white wine. Strasbourg is the home of much that is delightful in French cuisine. We all regretted our au revoir to France, but the jewel box of Switzer-

On Oct. 7-17, 1973, a group of members of the Missouri State Medical Association and their families enjoyed a five-day cruise up the Rhine River through Holland, Germany, France and Switzerland and spent 11 days in the heart of Europe as members of a MSMA-sponsored educational tour. This opportunity for Missouri physicians to attend the professional lectures aboard ship, meet and hear eminent physicians from these foreign countries and compare medical facilities and services was accompanied by the opportunity to enjoy the beautiful and romantic parts of Europe and the cuisine. Dr. Logue takes the reader to the ancient castles, famous cathedrals, art museums, fine restaurants and sun-drenched vineyards in his colorful account of this special trip to these countries he knows well. Dr. Logue is in the private practice of medicine.

Steep, sun-drenched vineyards and a series of wooded heights follow the banks of the Rhine River.

land could not wait for long, so soon we docked in Basel. Our last auf wiedersehen to Captain Gries and his crew was uttered from high on a mountain road when the *France* passed from view as we motored through the colorful Swiss countryside to beautiful Zürich, the most American of European cities.

From our first night in Amsterdam, postgraduate medical education was the most important, driving and time-consuming part of the Rhine Escape, for the first four hours of each day were dedicated to professional lectures and discussion in the spacious lounge of *Die Rhein Schiff France*. Of most interest was the vivid contrast between our approach to medical care and that of our host country. In Amsterdam, Dr. H. Weisz discussed "General medicine and how it is practiced in the Netherlands." Practice of medicine in the Netherlands is completely socialized, i.e., subsidized by the state. Missouri Show-Me physicians had great difficulty in comprehending that the Netherlands' approach to medical care is effective, economical, respected and efficient. The concept that medical specialists practice only in the hospital and that a practicing physician relinquishes direct control of his patient to a specialist upon hospital admission caused much distress and comment among us. This system, which is so unpalatable to us, is and has been the workable pattern in most European countries for years.

In Zürich, we visited the new Triemli Hospital, a multi-medical service complex built above ground over a large, subterranean, standby emergency hospital designed for use only in great emergency situations, including nuclear disaster. Dr. Morell, a hospital-based specialist in internal medicine at the Triemli Hospital, discussed with us the hospital-based specialist practice as it exists in partially socialized Switzerland. After a week of thought about medical practice in socialistic systems, it seemed to me that Show Me physicians were unimpressed and more determined that such a restrictive medical care system will not occur in our land. The shipboard seminar was to me very impressive for there was ample professional fare for any appetite—from skin to cervix, brain to drugs, infants to oldsters, advanced medical technology to common sense. Any professional in attendance could not help but expand his insight and professional knowledge.

The beautiful lakeside city, Zürich, became the hub of interesting and fascinating side trips. A trip to Lucerne high in the snowcapped Alps or a motor trip through Hansel and Gretel Land, the Black Forest, the long time home of Snow White and the Seven Dwarfs or the short trip into the green valley of Liechtenstein are but a few of our treasured memories.

Fine eating is a way of life in Zürich. Lovers of wild game can eat their fill here for the Swiss are second to none in preparing wild game for the table. An evening meal at one of the old guild houses along the Limmat River is a gustatory experience never equalled. The host at Zumpfthaus Rüden is the most gracious and accommodating maître d' I have ever met. I look forward to dining with him again. A midday snack of cheese fondue and wine makes even the grouchiest of husbands more patient with voraciously shopping wives. "Der Goldener Schnable" close by the Clock Tower offers the most delicate oriental selections for the discerning palate, and a leisurely evening in the Kronenhalle surrounded by original, signed pictures by Picasso, Chagall, Kandinsky, Miro, Klee and Braque is a modern art lover's expensive, eye-pleasing, stomach-pleasing extravagance. The shops of Zürich are second to none but the prices are high and bargains are nonexistent.

It was only a short and weary flight back to Missouri under the careful, considerate, patient direction of Mike Dolan and Georgette Stuparitz of the Marriott Travel Service, without whom the Rhine Escape could have resembled a stampede and been a "Traveler's Tragedy" instead of a "Tourist's Delight."

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

- The American Academy of Dermatology
- The Board of Directors of the American Academy of Family Physicians
- The Executive Board of the American Academy of Neurology
- The Committee on Drugs of the American Academy of Pediatrics
- The American College of Allergists
- The Executive Committee of the American College of Obstetricians and Gynecologists
- The Board of Regents of the American College of Physicians
- The Board of Trustees of the American Dental Association
- The Board of Trustees of the American Medical Association
- The American Psychiatric Association
- The Executive Committee of the National Association of Retail Druggists
- The Board of Directors of the Pharmaceutical Manufacturers Association
- The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

P·M·A

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Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent.

Synthroid-T_4

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WASHINGTON

Little noticed amid congressional confusion in attempting to deal with the energy crisis was the passage of a major health bill shortly before adjournment. The bill provides $375 million over five years to support the development of Health Maintenance Organizations (HMOs) across the country.

If signed into law by the President, the HMO legislation will go far in determining both consumer and provider acceptance of prepaid group health care. Despite a substantial flow of federal dollars into the experimental program, HMOs are not expected to encounter easy sailing. Ardent supporters of the program admit the trial period will be a rough one and caution against over optimism.

The speculation is that the President will sign the bill inasmuch as the money provided is not far over what the Administration originally requested, though the bill is much broader in scope than the President wished.

Two key provisions of the $805 million bill first approved by the Senate earlier this year were deleted or watered-down in conference enough to make the measure more palatable to the administration. One would have authorized federal subsidization of HMO premium costs for people who couldn't afford all or part of the cost. The other controversial Senate section would have created an independent Commission on Quality Health Care Assurance to supervise the HMO program. The compromise bill vests this responsibility with the Assistant Secretary of HEW for Health.

To qualify for federal aid, HMOs must meet a long list of federal standards of minimum benefits, stay open 24 hours a day, provide open enrollment and conform to numerous other requirements. Inducements are provided to attract people from poor and rural areas.

The Senate provision authorizing grants to assist HMOs in meeting operating deficits during the initial three years of operation was knocked out of the final bill, but a loan fund was retained to aid HMOs in meeting "a portion of initial operating costs in excess of gross revenues."

Copayments were barred under the Senate bill. However the conference agreed to allow HMOs to charge nominal copayments, but not to the extent they could be considered a barrier to seeking treatment. The conference committee said the co-payments are aimed at enabling an HMO "to market its benefit package at a competitive price."

The final bill requires larger employers to offer workers an HMO option when existing contracts for health insurance expire provided that a qualified HMO is operating in the area.

The bill does not provide a specific number of HMOs, but the bill's legislative history indicates the Congress had in mind around 100 programs.

* * *

Rep. John Rarick (D.-La.), principal congressional sponsor of legislation to repeal the Professional Standards Review Organization (PSRO) program, has dispatched a letter to all members of the House urging their support.

In his letter, Rarick said PSRO "is the hottest controversy facing medical doctors and their patients. The American Medical Association's prestigious House of Delegates voted to seek congressional repeal of this controversial peer-review law that goes into effect on 1 Jan. 1974."

Rarick quoted AMA President-Elect Malcolm C. Tood, M.D. as calling PSRO ". . . The greatest threat to the private practice of medicine of any piece of legislation ever passed by Congress."

The PSRO section of Medicare was added by the Senate and was never adequately debated, the lawmaker said. "The House did not even hold public hearings on this issue."

Rarick cited the *Wall Street Journal's* statement on PSRO—that points out that "the controversial legislation is laced with pointed references to 'new obligations imposed on' medical practitioners. It requires physicians to open their private files and hospital records to outside inspectors. Strong financian sanctions are provided for physicians who fail to comply."

Rarick wrote that he is concerned over the effect of the legislation on private medical practice in this country. "I am convinced that the medical profession has done an outstanding job of policing its own profession and establishing a high code of ethics. It simply does not make sense to bog down the medical profession with further government intervention that threatens the relationship between doctor and patient."

(Continued on page 64)

The Administration has moved to set clear fuel priorities in the health field as Congress was warned by health leaders that emergency care, drugs and devices and hospital care could be severely affected unless sufficient fuel is made available this winter.

Immediately following a hastily scheduled one-day hearing before the Senate Health Subcommittee, William E. Simon, head of the Federal Energy Office, said the pharmaceutical industry will get all the fuel it needs for production and research in order to maintain adequate supplies of essential drugs and medical supplies.

A spokesman for the American Medical Association testified there is a critical need to make special provisions for an adequate supply of motor fuel to meet the needs of medicine. J. Cuthbert Owens, M.D., a member of the AMA's Commission on Emergency Medical Services, said, "Physicians, nurses, life-support personnel, rescue workers and ambulances and other emergency motor vehicles must have a sufficient and continuous supply of gasoline to insure the provision of prompt care for the ill and injured. In addition, adequate fuel must be available to health care institutions, as well as to suppliers of necessary medical equipment and supplies."

Leo J. Gehrig, M.D., Vice-President of the American Hospital Association, said there is no federal natural gas allocation program for health care institutions.

"This substantial area of potential energy shortages significantly magnifies the effect of shortages of other fossil fuels on hospitals," Dr. Gehrig told the subcommittee. The proposed regulations published on Dec. 13, 1973, providing for mandatory allocation of middle distillates, allow hospitals only 100% of their 1972 base period volume, he pointed out. "With increasing natural gas interruptions, there is need for hospitals to receive 100% of current fuel requirements," Dr. Gehrig said.

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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

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Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®
(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.
ORAL SUSPENSION

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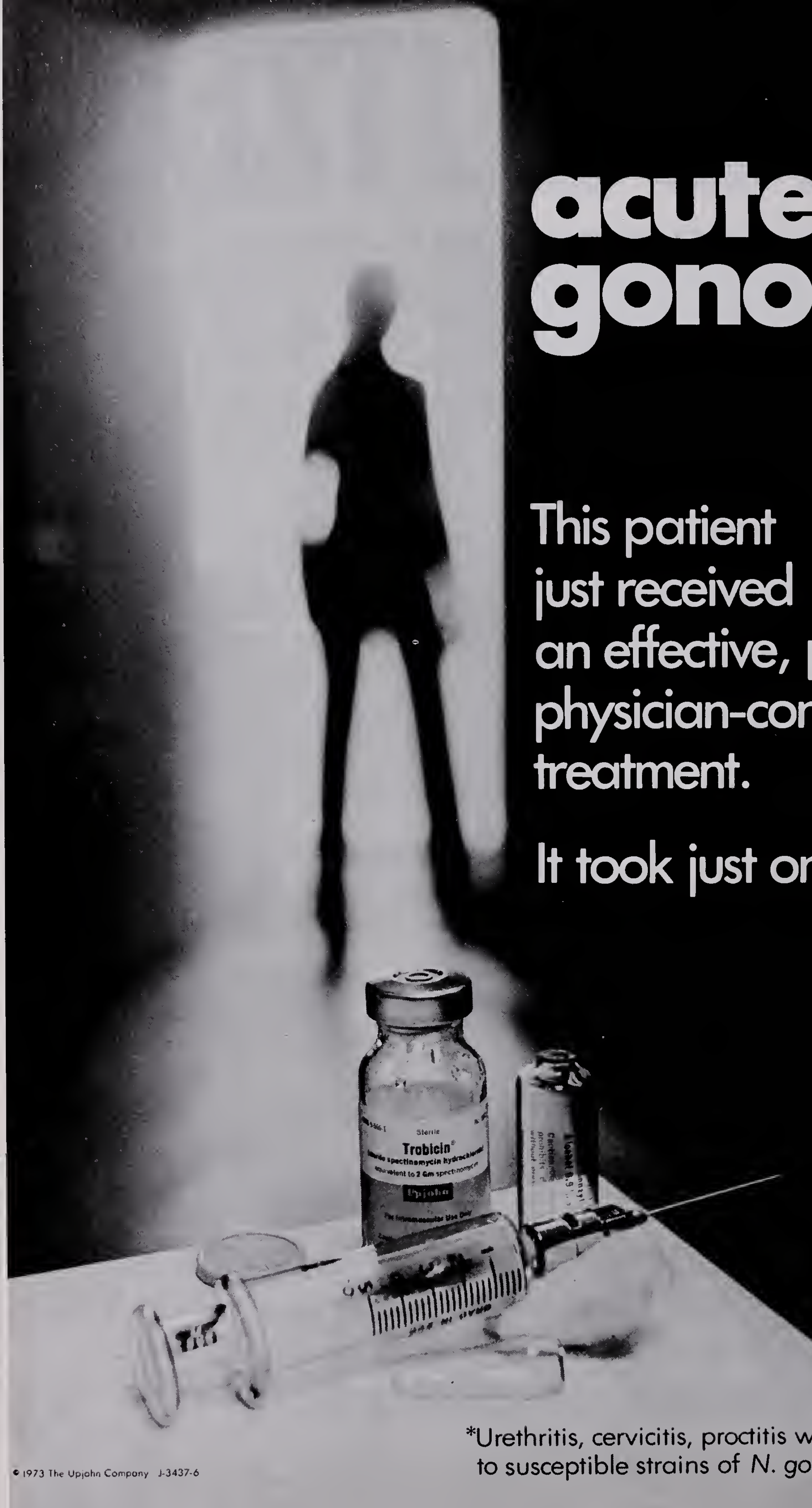
Please see prescribing information on facing page.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just received
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*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae.* The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular
.and **Trobicin®** 2 gm and 4 gm vials
sterile spectinomycin hydrochloride

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le Trobicin (spectinomycin hydrochloride) r Intramuscular Injection:
vials containing 5 ml when reconstituted diluent.
vials containing 10 ml when reconstituted diluent.
minocyclitol antibiotic active *in vitro* against strains of *Neisseria gonorrhoeae* (MIC 7.5) mcg/ml). Definitive *in vitro* studies have n no cross resistance of *N. gonorrhoeae* een spectinomycin and penicillin.
cations: Acute gonorrheal urethritis roctitis in the male and acute gonorrheal citis and proctitis in the female when due sceptible strains of *N. gonorrhoeae.*
traindications: Contraindicated in pa- previously found hypersensitive to spec- ycin.
nings: Not indicated for the treatment of ilis. Antibiotics used to treat gonorrhea mask or delay the symptoms of incubating ilis. Patients should be carefully examined monthly serological follow-up for at least nths should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae.*

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae.*
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

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The Upjohn Company, Kalamazoo, Michigan 49001

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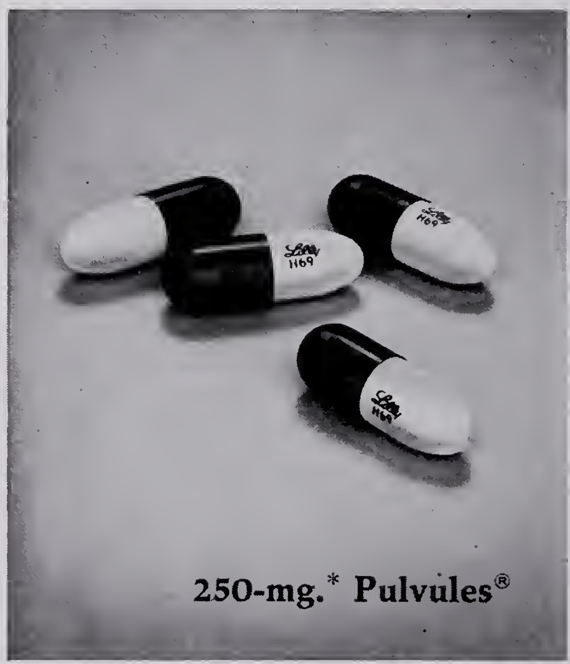

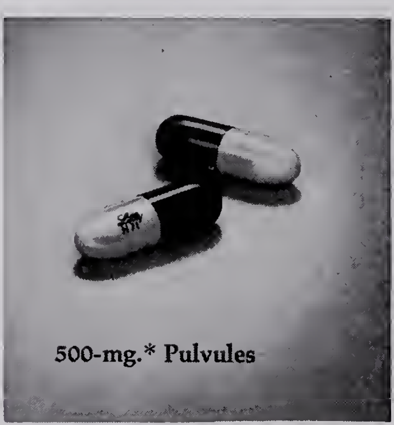

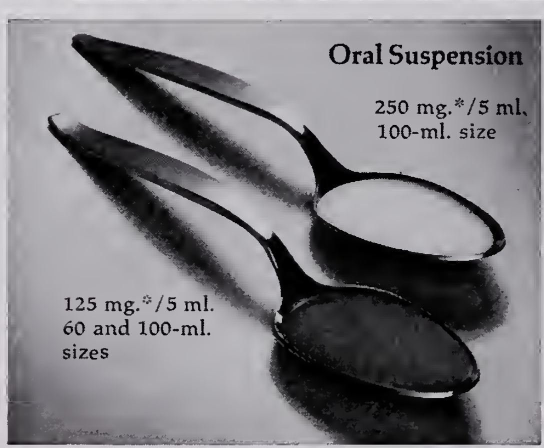

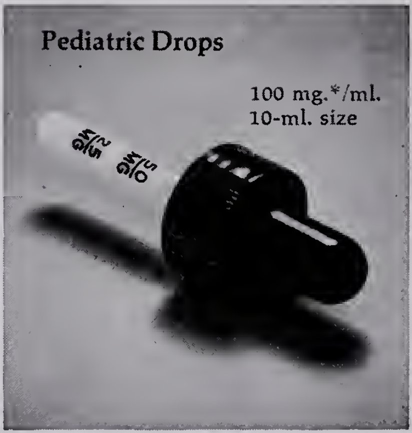

*Equivalent to cephalexin.

Additional information available
to the profession on request.

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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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YEU-TSU N. LEE, M.D., CARLOS SAY, M.D.
and JOSE M. HORI, M.D., *Columbia*

Peripheral Lymphocyte Counts and Prognosis in Malignant Lymphomas

Several reports correlating the prognosis of patients with cancer and the lymphocyte counts of peripheral white blood cells have appeared in the literature. Riesco[1] reported a positive significant correlation between five-year curability of cancer and the total number of peripheral lymphocytes among 589 patients with cancers of the cervix uteri, breast and other sites (19 had malignant lymphoma). Meyer *et al*[2] reported that in patients with mammary cancer, the lymphocyte level tended to increase in those patients in whom metastases regressed while they were receiving hormonal therapy. On the other hand, there was a consistent drop in the lymphocyte count in those in whom the disease progressed. Pendergrast *et al*[3] studied the peripheral lymphocyte counts of 61 patients before and after injection of a cancer vaccine. They reported that in patients who responded to immunization with tumor homogenate, peripheral lymphocyte counts increased while they decreased in patients who failed to respond. Holt and Lee[4] studied peripheral lymphocyte counts and results of therapeutic castration for advanced breast cancer. They found that the patterns of change in serial lymphocyte counts which occurred within six months after castration were most useful for correlation with objective response. Lymphocyte levels of patients who had an objective response recorded tended to stabilize after castration while most lymphocyte counts of those who did not have objective response decreased.

Regarding malignant lymphoma in particular, Rosenberg *et al*[5] studied 1,269 patients with non-Hodgkin's lymphoma. They found that if survival was analyzed as a function of the total lymphocyte count when first seen, the five-year survival rate of those with counts above 2,000 per cu mm was about 15% to 25% better than those whose counts were below 1,000 per cu mm (the difference in median survival was about 18 vs 3.2 months). The prognostic value of the total lymphocyte count was as great as for any other feature of the illness. Molander and Lacayo[6] reported that the recurrence rate for Hodgkin's patients after radiotherapy correlated with peripheral lymphocyte counts before treatment. Seventy-seven of 105 patients with recurrence had lymphocyte counts of 25% or less of the differential leucocyte counts, whereas 49 of the 95 patients without recurrence had such low counts ($p = 0.01$). They saw no such correlation in 300 patients with lymphosarcoma. Swan and Knowelden[7] found a clear difference in prognosis among three lymphocyte groups in a study of 328 histologically diagnosed patients with Hodgkin's disease. The worst prognosis was associated with lymphocyte counts of less than 1,000 per cu mm (five-year age-adjusted survival rate, 12%), and the best prognosis was in patients whose lymphocyte counts were more than 1,500 per cu mm (five-year survival rate, 35%).

The authors report findings on the correlation between peripheral lymphocyte counts at initial diagnosis and the survival rates of patients with Hodgkin's disease and other malignant lymphomas. These data are presented to stimulate further investigations of the role(s) of peripheral lymphocytes. The authors are from the Cancer Research Center and the Departments of Surgery of the Ellis Fischel State Cancer Hospital and the University of Missouri School of Medicine.

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Tubiana *et al*[8] studied prognostic factors in 454 patients with Hodgkin's disease. They found that the peripheral lymphocyte counts correlated with the histological subtypes. In patients with lymphocyte predominance lesions, 79% had lymphocyte counts of more than 900 per cu mm. The figure for patients with lesions of the lymphocyte depletion was 50%. The number of lymphocyte counts did not correlate with the result of tuberculin skin tests. Within each histological subtype, patients with lymphocyte counts higher than 900 had better survival rates than those with lower counts. They only presented survival data at one and three years after diagnosis and said that the differences (about 7% to 18% at the third year) were significant. Other reports[9-12] also suggested that the level of peripheral lymphocyte counts could have prognostic value in patients with Hodgkin's disease.

In this report, we wish to present our findings on the correlation between peripheral lymphocyte counts at initial diagnosis and the survival rates of patients with Hodgkin's disease and other malignant lymphomas. We found that Hodgkin's patients who had lymphocyte counts between 2,000 and 3,000 per cu mm and patients with non-Hodgkin's lymphoma having counts between 3,000 and 4,000 had better survival rates than patients with either lower or higher counts.

Clinical Material and Results

This is a retrospective and all-inclusive study of 527 patients who were seen and treated at the Ellis Fischel State Cancer Hospital (1940-1971) for Hodgkin's disease and other malignant lymphomas (including those which were diagnosed as lymphosarcoma, reticulum cell sarcoma and lymphoma, unspecified type).

One board-certified pathologist (JMH), who had a special interest in malignant lymphomas, reviewed all the original slides and confirmed the diagnosis in 448 patients. All the Hodgkin's lesions were reclassified according to the Luke's proposal, modified and recommended at the 1965 Rye Conference.[13] The non-Hodgkin's lymphomas were reclassified according to the terminology of Rappaport.[14] In addition, slides of 79 patients were not available for review but are included in this study because the diagnoses of Hodgkin's disease or lymphoma made by other pathologists were previously confirmed by pathologists at this hospital. Detailed analysis of the clinical courses and prognostic factors were then carried out on a total of 527 patients (163 with Hodgkin's disease and 364 with other malignant lymphomas).

Of these patients, 124 with Hodgkin's disease and 326 with other lymphomas had peripheral lymphocyte counts before therapy. Patients whose peripheral counts and smears suggested leukemia were excluded. The peripheral lymphocyte count was calculated from the percentage of lymphocytes in the total leucocyte count. Survival data presented are age, sex and decade adjusted and calculated by the life-table method.

Fig. 1 shows that in patients with Hodgkin's disease, the survival curve of those with lymphocyte counts in the category of 2,000 per cu mm to 3,000 per cu mm is better than those with counts between 1,000 to 2,000 and much better than those with counts less than 1,000 or more than 3,000. (The corresponding adjusted five-year survival rates are 49%, 23% and 0%; the ten-year survival rates are 30%, 18% and 0%.) The difference is statistically significant up to five years after diagnosis ($p < 0.02$). For comparison, those patients whose hemoglobin levels were more than 15 gm/100 ml had the best survival rate, while those with a hemoglobin level less than 9 gm/100 ml had the worst prognosis (the difference is only significant up to three years). Eosinophilia itself had no prognostic value. In our small series of 124 patients, we found that the distribution pattern of peripheral lymphocyte counts was similar among the different histological subtypes.

Fig. 2 shows that for the patients with non-

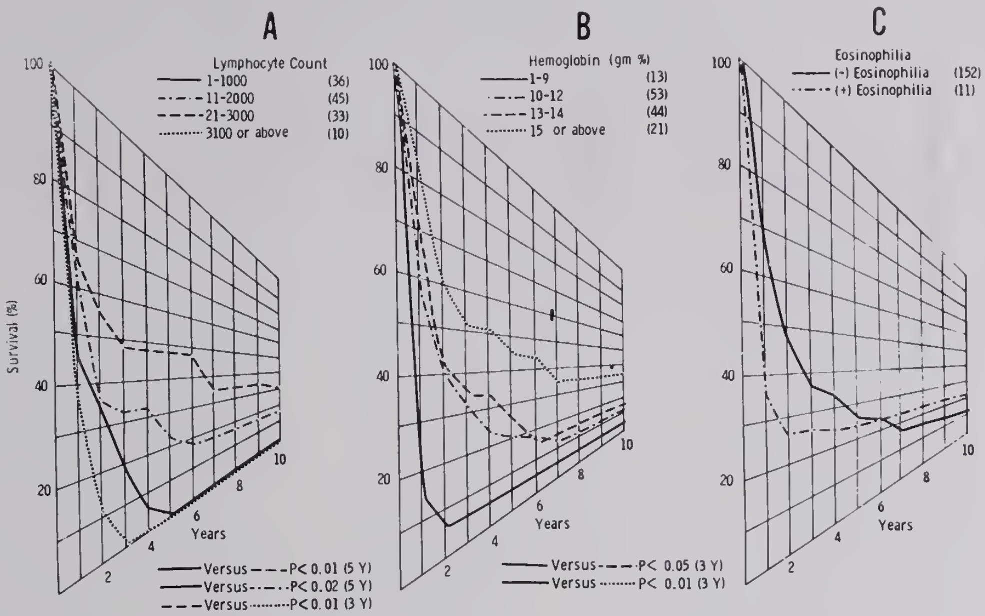

Fig. 1 Survival rates of 124 patients with Hodgkin's disease vs (A) peripheral lymphocyte count (per cu mm); (B) hemoglobin level (gm %); (C) presence or absence of eosinophilia.

Hodgkin's lymphoma, those with lymphocyte counts in the category of 3,000 per cu mm to 4,000 per cu mm had the best prognosis; those with 1,000 per cu mm to 3,000 per cu mm intermediary; and those whose lymphocyte counts were below 1,000 per cu mm and above 4,000 per cu mm had the worst prognosis. (The corresponding adjusted five-year survival rates are 52%, 30% and 16%; the ten-year survival rates are 39%, 18% and 5%. The cumulative differences are statistically significant up to ten years, $p < 0.05$.) This difference in survival rates is especially prominent for patients with the histological lymphocytic subtype and not so obvious for patients with the histiocytic, mixed cell or pleomorphic patterns. Strangely enough, the favorable effect of this lymphocyte count level (3,000-4,000 per cu mm) manifested itself only in patients with advanced disease (Stages III and IV) and was not so obvious in patients with early lymphomas (Stages I and II). In all clinical stages, patients with lymphocyte counts below 1,000 per cu mm had the lowest survival rate.

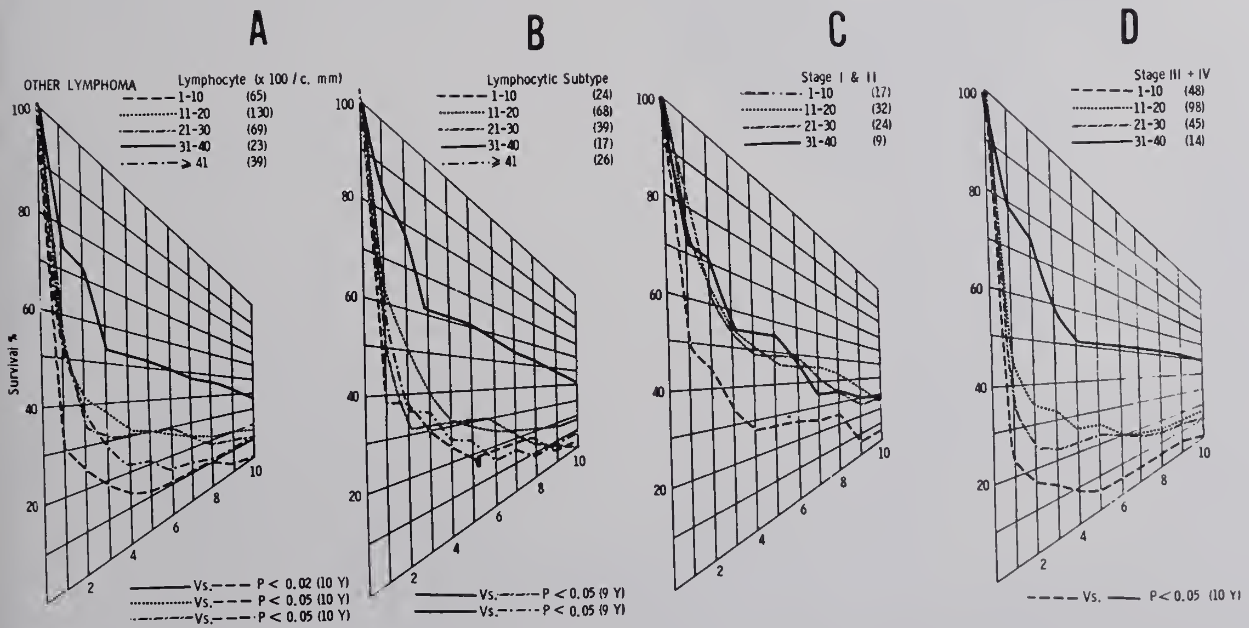

Fig. 2 Survival rates of 326 patients with non-Hodgkin's lymphoma vs peripheral lymphocyte count (x100 per cu mm): (A) all patients; (B) patients with lymphocytic lymphoma, (C) patients with early disease; (D) patients with late disease.

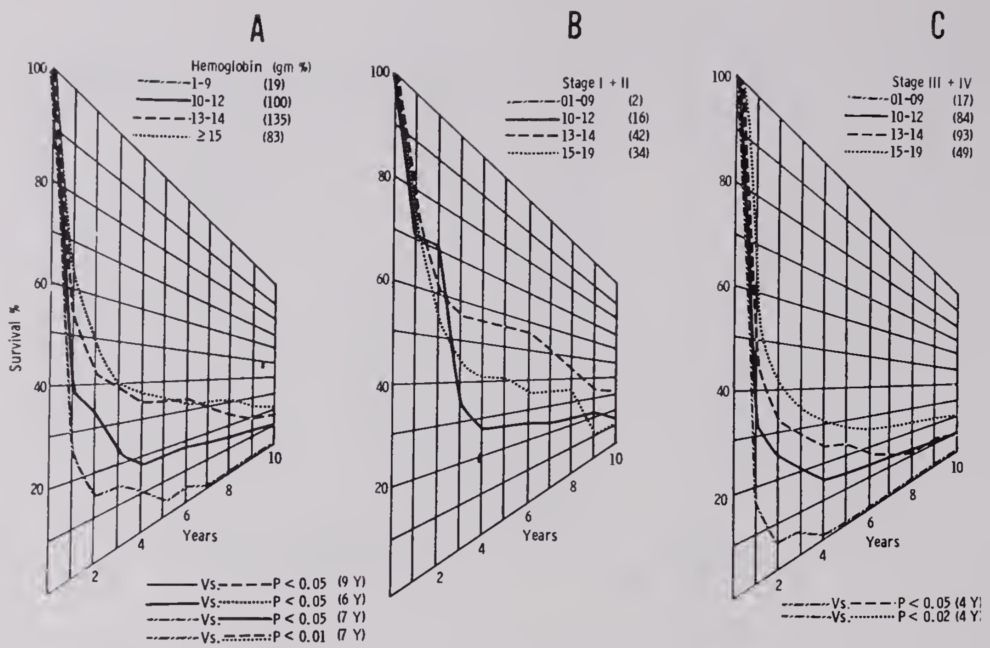

Fig. 3 Survival rates of 326 patients with non-Hodgkin's lymphoma vs hemoglobin level (gm %): (A) all patients; (B) patients with early disease; (C) patients with late disease.

The hemoglobin level at the time of diagnosis also has prognostic values (Fig. 3). Those patients whose hemoglobin level was more than 13 gm/100 ml did much better, and those whose level was less than 9 gm/100 ml had the worst prognosis. This was true for both early and late clinical stages.

Discussion

We purposely present the data of hemoglobin levels side by side with the data of peripheral lymphocyte counts to remind ourselves that there are multiple single tests which seem to have individual prognostic values, some of which are statistically significant and some are not. We really do not know if they are truly important by themselves or if they only reflect something else which we may or may not measure quantitatively as yet.

Clinical staging and pathological subtypes of malignant lymphoma were two of the most important factors influencing survival. In the preliminary analysis of our own data (Lee *et al*[15]), we found that patients in Stages I and II had significantly better survival curves statistically than those in Stages III and IV. Of patients with Hodgkin's disease, those having nodular sclerosis had the best prognosis, whereas those with lymphocytic depletion had the worst. In patients with other lymphomas, the well-differentiated lymphocytic type had the best prognosis. In both Hodgkin's and non-Hodgkin's lymphoma, women and young adults of the age group of 21 to 40 had better survival curves than other patients, although statistically these differences were not significant.

Thus, we attempted to analyze the relationship of lymphocyte counts and all other factors known to influence prognosis in patients with malignant lymphoma. In patients with Hodgkin's disease, the only apparent correlation is that patients who presented with diseases in Stages I and II appeared to have lymphocyte counts in the more optimal range. Of the 33 Hodgkin's disease patients with a lymphocyte count of 2,000 per cu mm to 3,000 per cu mm, 55% had Stage I or II disease on presentation in contrast to only 40% of those with either lymphocytopenia (< 1,000) or lymphocytosis (> 3,000). For patients with early lymphomas, 39% of those whose lymphocyte counts were between 3,000 and 4,000 had Stage I or II disease in contrast to only 22% of those whose lymphocyte counts were of the two extremes (less than 1,000 per cu mm or more than 4,000 per cu mm). However, none of these differences is statistically significant. We already have shown (Fig. 2) that the favorable effect of optimal lymphocyte counts of 3,000 per cu mm to 4,000 per cu mm is exhibited only in Stages III and IV. In addition, non-Hodgkin's patients with lymphocyte counts of 3,000 to 4,000 had the highest proportion of well-differentiated lymphocytic type (39%). It also is in this particular histological type that patients with lymphocyte count of 3,000-4,000 had the best prognosis.

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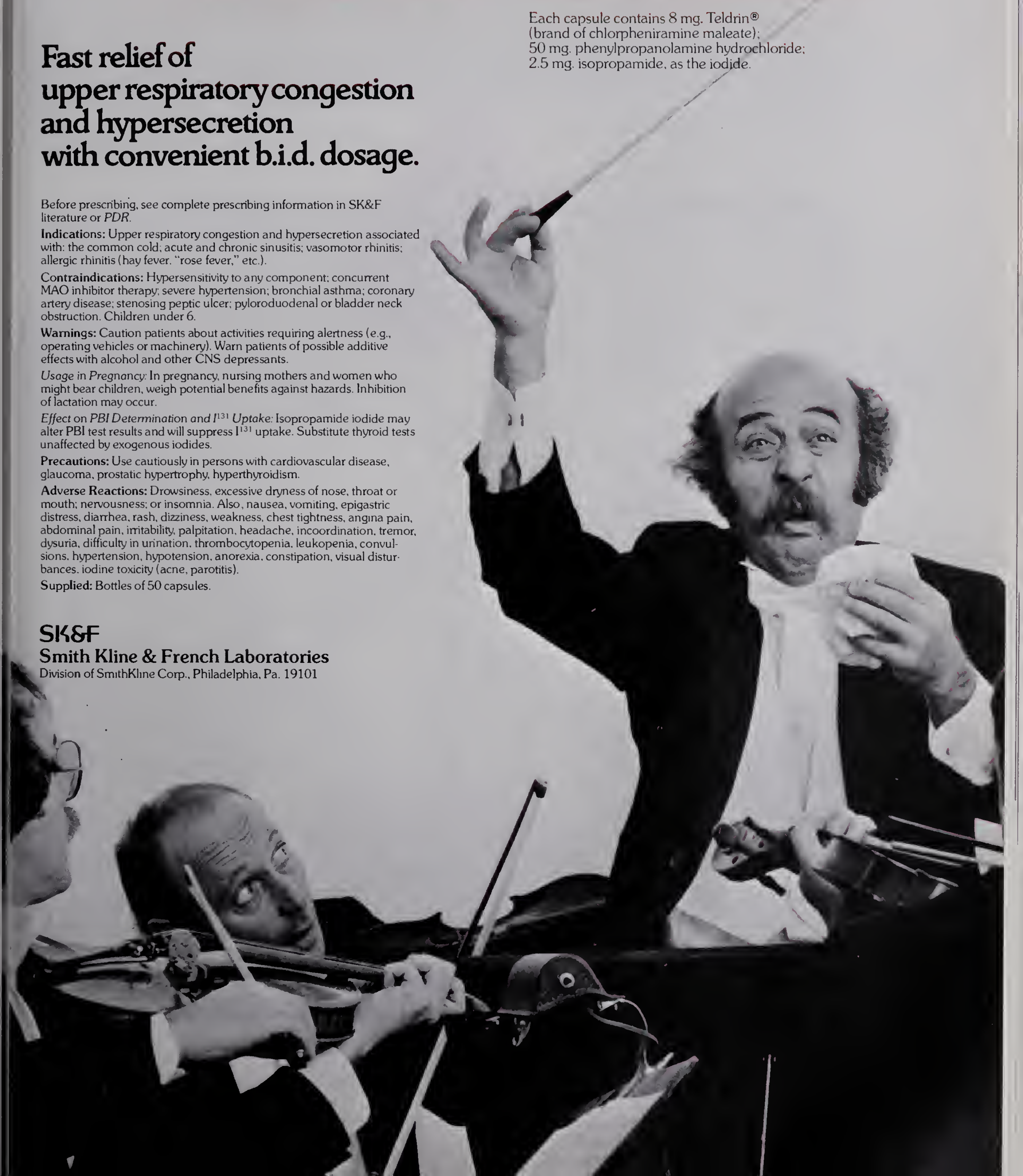

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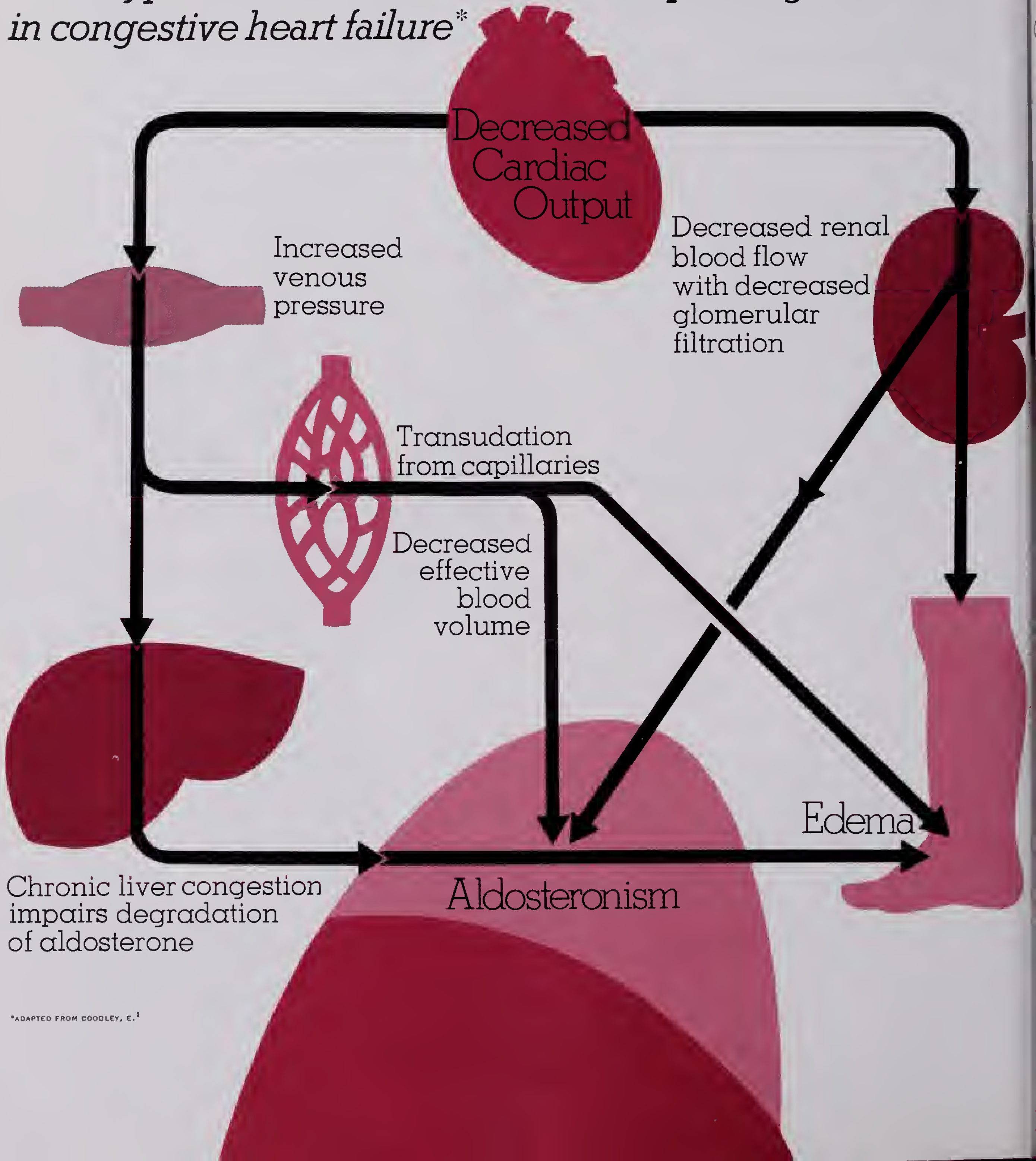
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- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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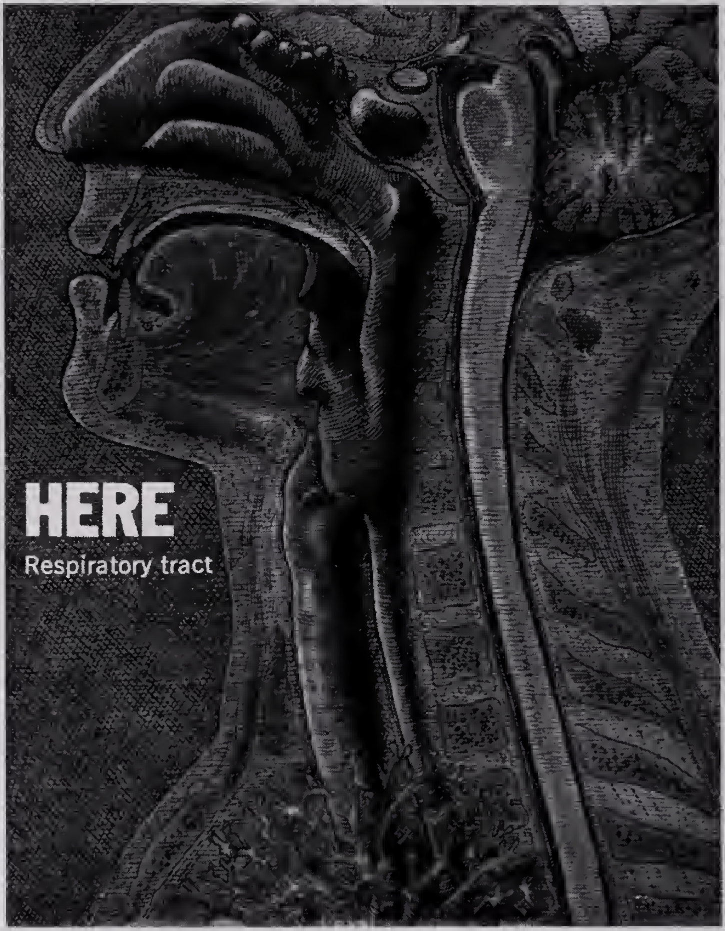

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who found that the postradiotherapy recurrence rate in 200 Hodgkin's disease patients correlated with the level of peripheral lymphocyte counts before treatment, we could not detect such a relationship among our small series of patients. (Only 87 patients who had radiotherapy had peripheral lymphocyte counts recorded before therapy.)

But with respect to peripheral lymphocyte counts, our results appear to corroborate the findings of Rosenberg *et al*[5] and others.[7–12] All the data show that the level of peripheral lymphocyte counts can be correlated with different survival results of patients with Hodgkin's disease and other malignant lymphomas, regardless of the different types of therapy they received. However, the specific level of peripheral lymphocyte counts which correlated with the best prognosis is different in each study. In patients with non-Hodgkin's lymphoma, Rosenberg *et al*[5] found that this should be more than 2,000 per cu mm. In patients with Hodgkin's disease, better survival rates were reported in those with counts above 800,[11] 900,[8] 1,000[9] and 1,500.[7, 10] We determined counts between 2,000 to 3,000 to be best for Hodgkin's disease, whereas 3,000 to 4,000 was best for those with non-Hodgkin's lymphoma. (About 27% of the Hodgkin's patients in our series had lymphocyte counts in this favorable range, whereas only 7% of those with other lymphomas did so.) It is hard to explain why a non-leukemic lymphocytosis in excess of 3,000 is associated with a poor prognosis in Hodgkin's disease, but a superior prognosis in Stage III and IV non-Hodgkin's lymphoma.

Several factors could count for this degree of variability. The most common is probably related to the method of calculating the peripheral lymphocyte count and its inherent variability. (The number of lymphocytes equals total white cell count times percentage of differential count of white cells which appear to be lymphocytes.) Aisenberg[16] found that lymphocytopenia is characteristic of the terminal phase of Hodgkin's disease. He used the average figure of at least three different and sequential lymphocyte counts. Zacharski *et al*[17] studied the value of normal leukocyte counts in 507 healthy adults and found no significant variation with age and sex. But they found that the upper normal limits (97.5 percentile) of lymphocyte counts were lower than previously reported. They determined that the figures covering 95% of the normal values were between 832 and 3,140. They quoted several other authors who established the range of normal lymphocyte counts as 600-4,500, 1,500-3,500, 1,000-4,500, 1,490-3,930 and 1,000-4,800.

It is obvious that like other types of neoplasms and diseases, there are many different clinical and pathological factors which influence the prognosis of patients with malignant lymphoma. According to Osgood,[18] peripheral lymphocyte is only a small segment (about 0.02%) of the total lymphoid tissues scattered throughout the body. Although "lymphocytes are the major carriers of cell-mediated immune mechanisms and the lymphocyte level is an index of cellular-immune competence,"[19] it is surprising that a simple test such as peripheral lymphocyte count could be used as a prognostic factor to correlate with final survival. Fully realizing that the diagnosis of malignant lymphoma implies a complex disease with many heterogenous and entangled facets, we present these data to stimulate further investigations of the role(s) of peripheral lymphocytes.

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Lomotil Toxicity in Children

Case Report

There have been 11 reports of Lomotil poisoning in children in an overdosage situation.[1–11] Toxic effects of both components of the tablets have been observed.[4]

Despite widespread use of Lomotil (diphenoxylate hydrochloride with atropine) as an antidiarrheal agent, numerous difficulties have prevented an accurate chemical determination of diphenoxylate in biological specimens. Thus, toxic levels were not reported in any of the variously reported cases of Lomotil poisoning.[1–11] Until recently, diphenoxylate metabolism in humans was unknown.[12] Review of the reported cases of Lomotil poisoning in children discloses serious morbidity and mortality up to several days after ingestion. The following case report emphasizes the importance of supportive care in preventing a respiratory death in Lomotil-poisoned children.

Case Report

A 29-month-old girl was admitted to St. Louis Children's Hospital because of Lomotil ingestion. Between 10 PM the previous night and 6:30 AM the day of admission, the child consumed 18 tablets (2.5 mg of diphenoxylate hydrochloride and 0.025 mg of atropine in each tablet). At 7 AM, her respiratory rate was 10 per minute, pulse rate was 120 to 140 per minute and blood pressure was 80-90/30-50 mm Hg. Respirations were shallow and the patient was cyanotic. Mask oxygen was administered. Gastric lavage with isotonic fluid was performed. Intravenous fluids (5% dextrose and lactated Ringer's solution) were started and a catheter was inserted into the bladder. At 8 AM, 0.012 mg of levallorphan tartrate (Lorfan) was given intramuscularly. Apneic periods necessitated endotracheal intubation and positive pressure ventilation. At 9:15 AM and 9:30 AM, 0.2 mg of nalorphine hydrochloride (Nalline) were given intravenously. Alertness and spontaneous respiratory effort improved and the child extubated herself.

This case report of a two-year-old girl who ingested 18 tablets of the antidiarrheal agent, Lomotil, emphasizes the importance of supportive care in preventing a respiratory death in Lomotil-poisoned children. Hospitalization for every serious case of Lomotil ingestion seems advisable. Dr. Shearer is Instructor in Pediatrics and Dr. Keating is Assistant Professor of Pediatrics and Director of the Division of Gastroenterology, The Edward Mallinckrodt Department of Pediatrics, Washington University School of Medicine and the Division of Gastroenterology, St. Louis Children's Hospital. Dr. Hutsell is Senior Research Investigator, Department of Biological Research (Pathology-Toxicology), Searle Laboratories. Dr. Shearer is the recipient of USPH Special Research Fellowship 1-FO3-A153856-02 from the National Institute of Allergy and Infectious Diseases.

On arrival at St. Louis Children's Hospital, the child was semicomatose. She displayed peri-oral and acrocyanosis. Her respiratory rate was 36 per minute with shallow excursions, pulse rate was 140 per minute and blood pressure was 90/50 mm Hg. The child did not respond to light, pin stimulation or voice, although she became combative when more vigorously stimulated. The extraocular eye movements were intact as demonstrated by the oculocephalic reflex maneuver. The pupils were 3 mm in diameter and responded sluggishly to light; there was no papilledema. Abdominal reflexes, plantar reflexes and corneal reflexes were markedly diminished. Deep tendon reflexes at the knee and ankle were hyperactive.

Laboratory studies revealed arterial blood gases equal, P_AO_2 of 40 mm Hg, P_ACO_2 of 37.1 mm Hg, pH 7.22. Serum chemistries included sodium—137 mEq/liter, potassium—3.8 mEq/liter, chloride—105 mEq/liter, bicarbonate—20.5 mEq/liter, blood urea nitrogen—12.7 mg/100 ml, creatinine—0.96 mg/100 ml, calcium—9.4 mg/100 ml, glucose—87 mg/100 ml and salicylate level—3.6 mg/100 ml. Liver function studies showed serum glutamic-oxalacetic transaminase—43 units, serum glutamic-pyruvic transaminase—10 units, serum alkaline phosphatase—11.7 units, bilirubin—0.4 mg/100 ml and prothrombin activity—87% of normal.

Pressure in the lumbar cistern measured at the time of lumbar puncture was greater than 250 mm of spinal fluid. Cerebrospinal fluid protein was 25 mg/100 ml and the glucose was 60 mg/100 ml. Examination for cellular elements and bacteria in the spinal fluid was negative.

Urinalysis revealed a specific gravity of 1.002, pH 5.0, 4+ test for glucose (IV fluids running), negative test for protein and acetone. An electrocardiogram confirmed the sinus tachycardia. Hemoglobin value, hematocrit level, white blood cell count, differential cell count and platelet count were all within normal limits.

Hospital Course: Inspired oxygen concentration was increased by mask in an attempt to improve the arterial oxygen content. The patient continued to maintain respiration without difficulty. A fever of 39C developed at 2 PM on the day of admission and the child was started on ampicillin 200 mg/Kg/day and kanamycin 15 mg/Kg/day. Concomitant with the fever, a pronounced malar rash developed (Fig. 1). Except for growth of *H. influenzae* from tracheal secretions, cultures of blood, urine and stool were nonrevealing. Intravenous fluids (Isolyte M) were administered at a rate of 1000 ml/M^2/day in an effort to minimize possible cerebral edema. At 6 PM, the child spontaneously opened her eyes and focused on objects in the room. Pupils at that time were briskly responsive to light and abdominal and plantar reflexes had returned. At 11 PM, she was talking to her parents, although masked oxygen was still required to maintain an acyanotic state. Some confusion and combativeness persisted through the subsequent 48 hours. An electroencephalogram 48 hours after admission revealed a diffuse arrhythmic delta slow activity consistent with metabolic or organic process (Fig. 2). A chest radiograph during the second hospital day revealed persistent infiltrates in the right upper, right lower and right middle lobes. In addition, she had developed a large pneumomediastinum. Improvement in these processes occurred gradually over the next five days. She was discharged one week after admission and has subsequently remained in good health.

DISCUSSION

Ament describes a two-phase reaction of Lomotil overdosage.[4] The first phase, due to atropine, lasts two to three hours and is characterized by sudden high fever, generalized flush of the skin and tachypnea. Lethargy, coma, hypoactive reflexes and diminished muscle tone signal the onset of the second phase, which is thought to be due to the diphenoxylate which causes depression of the central nervous system. Temperature falls, respirations become shallow and may cease and the pupils are miotic and unresponsive. The second phase can be prolonged[1] and repeated episodes of apnea can occur. This is thought to be due in part to undigested tablets in the stomach from decreased gastric motility secondary to diphenoxylate.[4] The patient we describe does not demonstrate this two-phase reaction well. The time of ingestion is uncertain and pertinent observations of the child's initial reactions to the drug are lacking. The child did develop a high

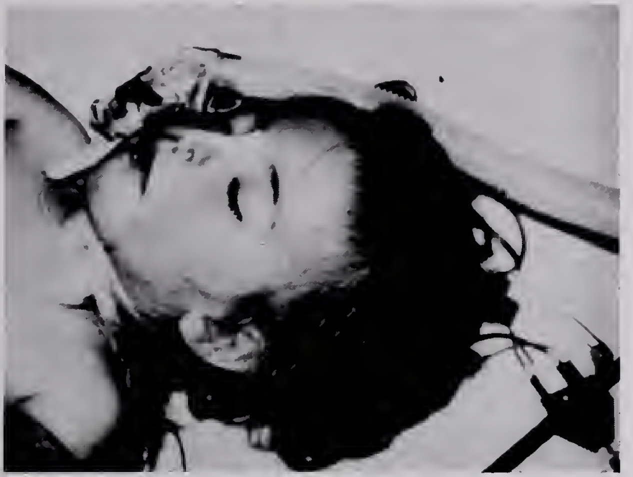

Fig. 1 Two-year-old girl with Lomotil overdosage demonstrating pronounced malar flush concomitant with high fever.

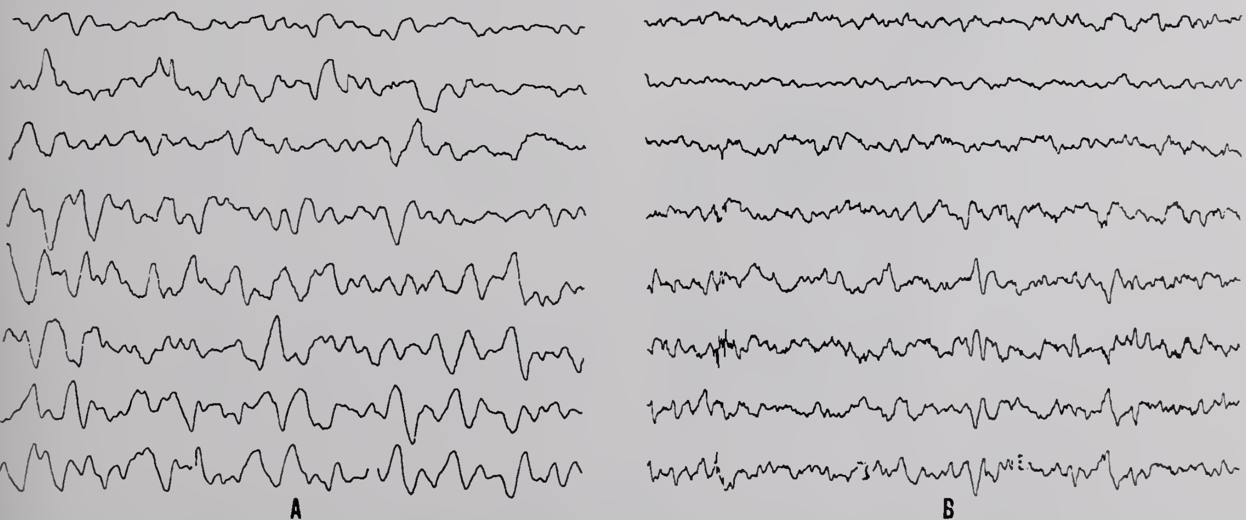

Fig. 2 Electroencephalograms of child with Lomotil toxicity. (A) Two days after Lomotil ingestion. (B) Five days after ingestion.

TABLE 1

SUMMARY OF PEDIATRIC CASES OF LOMOTIL POISONING

Reference	*Patient*	*Drug Ingested*	*Hours Before Onset of Symptoms*	*Clinical Features*	*Treatment*	*Outcome*
Ginsberg	10 patients (1-36 mo)	25-110 mg (10 patients)	120 after 1st dose (1 patient, others not described)	Lethargy and decreased deep tendon reflexes (10/10 patients). Miosis (9/10 patients). Skin flush and apnea (5/10 patients). Seizures (4/10 patients).	Nalorphine IV 5.0 to 10 mg/1.73 sqM., intravenous fluids, 50% O_2 inhalation (1 patient, others not described).	10 Survived
Snyder Moffenson, Greensher	22 mo girl	8-10 tab	4	Sleepiness, flushed face, miotic pupils, tachycardia, diminished deep tendon reflexes. T 38C, rhinitis, cough, 8 hours after ingestion, respirations became shallow and developed acrocyanosis.	Emesis induced with syrup of Ipecac. High humidity oxygen inhalation. Naloxone 0.05 mg given IM.	Survived
Wheeldon, Heggarty	2 yr girl	35-40 tab	2	Drowsy, slow respiration rate. 10 and 17 hours later respiratory arrest.	Gastric lavage, supportive care, nalorphine hydrobromide IV 7 times 4 hours apart.	Survived
Ament	2 yr boy	30-40 tab	4	Febrile (39.8C), flushed, tachypneic, lethargic. Became apneic, rigid, and cyanotic. Unresponsive.	Stomach aspirated, caffeine sodium benzoate 15 mg/Kg IM twice, nalorphine hydrochloride 2 mg IV 12 times, endotracheal intubation, intravenous fluids.	Survived
	27 mo girl	40 tab	3	Febrile (40C), lethargic, staggering, pupils miotic and unreactive to light, diminished muscle tone and reflexes. Became apneic and rigid by 4-5 hours.		Survived
Bargman, Gardner	20 mo girl	16 tab	2	Drowsiness progressing to deep sleep 6-7 hours, dyspnea, flaccid, unresponsive. By 14 hours pale, comatose, diminished reflexes, responded to deep pain, pupils constricted, gasping respirations, tachycardia, EEG showed cortical irritability and disturbance of deep sleep brain function. Evidence for cortical blindness. Transient azotemia	Nalorphine hydrochloride 2 mg IV, endotracheal intubation.	Survived

				(BUN 41 mg/100 ml) and transient hypertension (BP 150/110 mm Hg).		
Ginsburg, Angle	5 yr girl	42 ml over 24 hours	28 after first dose	Unresponsive, severely depressed respirations, cardiac arrest, seizure (generalized and right sided), unresponsive to deep stimulation, pupils miotic but responsive to light. Progressive coma, seizures, anuria, azotemia, congestive heart failure, cardiorespiratory arrest 3½ days later. Post-mortem examination showed severe cerebral edema, subarachnoid hemorrhage, pulmonary atelectasis, hydropic degeneration of the proximal convoluted tubule of the kidney.	Tracheostomy, intracardiac epinephrine, external cardiac massage, rectal secobarbital 45 mg, nalorphine 5 mg IV, hypertonic mannitol IV.	Died
Harries, Rossiter	2 yr boy	12 tab	6	Grunting, mild respiratory distress. By 8 hours cardiorespiratory arrest. By 12 hours, hypothermic, fixed dilated pupils, unresponsive. Post-mortem examination showed gross cerebral edema.	Supportive care, nalorphine hydrochloride IV after 12 hours.	Died
Henderson, Psaila	2 yr girl	6 tab	3	Lethargic and sleepy. By 9 hours unconscious, shallow respirations, stertorous breathing, cyanosis. By 10 hours seizures and apnea. By 11 hours cardiac arrest. Aspiration pneumonia.	Supportive care, nalorphine hydrochloride 2.5 mg. IM twice.	Survived
Riley	2 yr boy	30 tab	Unknown	Vomiting, staggering, stupor, febrile (39.5C), slow and irregular respiration, miotic pupils. Unconscious for 3 days.	Levallorphan IV, intravenous fluids.	Survived
King, Powell	5 mo girl	15 ml over 12 hours	12 after first dose	Comatose, pupils reacted sluggishly to light, upward gaze, dyspnea, suprasternal tugging, bladder distention, urinary retention.	Intravenous calcium gluconate (no amount specified), intravenous fluids, 60% O_2 inhalation, bladder catheterization.	Survived
Canby	2 yr boy	8 tab	2	Sleepiness progressed to apnea and cyanosis by 8 hours. Tachycardia, febrile (39.6C), pupils reacted sluggishly to light, bladder distention, urinary retention. Glucosuria.	Induced vomiting, 7.5 mg nalorphine hydrochloride IV, bladder catheterization.	Survived

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[*] 1 tablet is equivalent to 5 ml Lomotil. Each contains 2.5 mg diphenoxylate and 0.025 mg atropine sulfate.

fever and facial flush, but it was well after ingestion of the drug and after the apneic periods characteristic of the second phase. The fever may have been due to the pneumonia on the right side, which probably was due to iatrogenic aspiration. The review of the pediatric cases of Lomotil poisoning (Table 1) supports the two-phase reaction observed by Ament.[4]

Reversible depression of the brain wave function is shown in Fig. 2. The transient abnormalities may have been due to the diphenoxylate itself or, probably, due to hypoxia. Electroencephalographic irregularities in Lomotil overdosage have been reported before.[5] Cerebral edema was documented in the two fatalities reported.[6, 7] Once again, this most likely is due to cerebral hypoxia. Our patient gave some evidence of an elevated cerebrospinal fluid pressure. She also exhibited a return of reflexes with improved clinical condition.

This case represents another episode of serious toxicity in the pediatric age group caused by ingestion of an excessive amount of diphenoxylate and atropine in the antidiarrheal preparation marketed as Lomotil. The true incidence is unknown, but observations of several milder cases in our own hospital suggest that it exceeds the number published.

The clinical signs and symptoms may conform to the pattern described by Ament, with atropinism predominating in the early course followed by central nervous system depression. However, if recognition of the ingestion is delayed, as in our case, the latter process may dominate the presentation.

Narcotic antagonists have been used in all but one of the reported cases, including the two which ended in death. Nalorphine (Nalline) 0.1 mg/Kg has been used principally, but Naloxone hydrochloride (Narcan) 0.005 mg/Kg, a newer narcotic antagonist which is said to cause no respiratory depression of its own, may be given. Intravenous injection is preferable; repeated injections may be necessary until respirations improve. However, variation in dose, clinical status at the time of administration and details of clinical response in the published reports makes critical evaluation of these agents impossible, although positive response was noted by some authors.[1–5, 8] Lavage or induced emesis might be of value in retrieving undissolved pills even hours after ingestion if the anticholinergic action of the drugs has delayed gastric emptying. Vigorous support of ventilation and blood pressure based on frequent assessment of clinical status is basic to survival in all forms of central nervous system depression and should not be postponed while awaiting effects of specific antagonists.

Recently, the Federal Food and Drug Administration, with the cooperation of the manufacturer, has suggested new recommendations for the use of Lomotil in children. The use of Lomotil is contraindicated in children less than two years of age, and the dosage in older children should adhere strictly to the recommendations on the package insert.[12]

Karim *et al* have studied the absorption, excretion and biotransformation of ^{14}C-diphenoxylate hydrochloride in three men.[13] The parent drug is in ester form and is metabolized principally to the acid form, diphenoxylic acid and hydroxydiphenoxylic acid.[13] Major excretion of the absorbed drug is by fecal elimination probably via biliary excretion of diphenoxylate metabolites while urinary excretion plays a minor role.[13] These studies also indicated that there was a "deep" compartment which strongly bound diphenoxylate. This could account for the latency of the appearance of clinical symptoms in overdosed children.[13]

We have made preliminary observations on diphenoxylate metabolite levels of urine samples from the child presented. By methods of gas-liquid chromatography, we have estimated that the urinary half-life is seven hours and the elimination constant in 0.10^{-1}, which is in good agreement with the finding of Karim *et al.*[13] We intend to analyze further the collected specimens when improvements in methodology have been obtained.

Acknowledgement: The authors express appreciation to Dr. Richard D. Torkelson for assistance with patient management.

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Infant Transport: Two Years' Experience

St. John's Mercy Medical Center is a 675-bed general hospital located in west St. Louis county. There were 4,630 liveborn infants delivered in the obstetrical service in 1971 and 4,508 in 1972, making it one of the largest maternity services in the state. About 90% of these women had private obstetricians and approximately 10% received their care from obstetrical house officers supervised by an attending obstetrician. The newborn babies of these "clinic" mothers were cared for by an attending pediatrician.

Newborn babies who are transferred from St. John's Mercy Medical Center for more intensive care are sent to either the Children's Hospitals of The Washington University or St. Louis University schools of medicine. This report analyzes the characteristics of those newborn babies transferred to these two referral centers.

Methods

The records of newborn infants subsequently transferred were examined retrospectively. The percentage of all liveborn infants transferred, the relative proportion of private and "clinic" patients transferred, the diagnoses made prior to transfer, whether the babies lived or died and the sex ratio of those involved were analyzed.

Results

Table 1 reveals an increase in the percentage of babies transferred from 1% in 1971 to 1.6% in 1972. This occurred in spite of a decrease in the total number of live births in 1972. Referring to Table 2, it is evident that 1.0% of babies delivered in the private service and 0.9% in the clinic service were transferred in 1971. In 1972, this number was 1.6% for private newborn infants and 2.0% for clinic newborn infants.

TABLE 1

TOTAL LIVEBORN INFANTS DELIVERED AND TRANSFERRED
Jan. 1, 1971 through Dec. 31, 1972

	1971	*1972*
Total deliveries	4,630	4,508
Total transfers	47	73
Percent of total deliveries transferred	1.0	1.6

TABLE 2

TOTAL LIVEBORN INFANTS DELIVERED AND TRANSFERRED AS DISTRIBUTED BETWEEN PRIVATE AND CLINIC SERVICES

	1971	*1972*
Private service deliveries	4,195	4,003
Clinic service deliveries	435	505
Transfers		
Private	43 (1.0%)*	63 (1.6%)
Clinic	4 (0.9%)	10 (2.0%)

* The percentage of babies delivered in the private and "clinic" groups respectively, who were transferred.

The diagnoses made in the babies prior to their transfer were pulmonary disorders (39), prematurity (35), cardiac problems (22) and central nervous system disorders (23). These four cate-

This analysis of sick, newborn babies who were transported from a suburban community hospital to university neonatal intensive care units clearly revealed the disadvantage of the sick male. Prematurity, pulmonary, cardiac and central nervous system problems accounted for 69% of the diagnoses made prior to transfer. Dr. Gellman is from the Department of Pediatrics and Sister Michael Marie Flannery is Supervisor of Nursing for the Obstetrical and Newborn Services, St. John's Mercy Medical Center. Dr. Gellman also is Instructor of Clinical Practices, Washington University School of Medcine.

TABLE 3

DIAGNOSES MADE ON INFANTS PRIOR TO TRANSFER—172
(Some Infants Had More Than One Diagnosis)

Pulmonary	39
Prematurity	35
Central nervous system	23
Cardiac	22
Gastrointestinal	17
Infection	9*
Hematological	7
Metabolic	5
Genetic	5
Musculo—skeletal	4
Miscellaneous	4
Neoplastic	2

* Four of six cases of sepsis were questionable.

TABLE 4

OUTCOME OF BABIES TRANSFERRED
(Yearly Basis and by Weight)

	1971	*1972*
Outcome of transfers	9 Died (19%) 38 Recovered	18 Died (25%) 55 Recovered
	Total	*Lived/Died*
Outcome by weight		
500-1,000	3	1/2
> 1,000-1,500	14	11/3
> 1,500-2,000	16	11/5
> 2,000-2,500	14	9/5
> 2,500	73	61/12

gories accounted for 69% of all diagnoses made (Table 3).

In Table 4, it is apparent that the percentage of babies transferred who died rose from 19% in 1971 to 25% in 1972. The number of babies transferred also increased over this time. The birth weights of 47 of the 120 babies transferred ranged from 500 gm to 2,500 gm.

The sex ratio of babies transferred was in the male to female ratio of 1.85 to 1.0. The same relationship was true for those babies who died, but the ratio was 2.85 to 1.0 (Table 5).

TABLE 5

SEX RATIOS OF BABIES

-	*Male*	*Female*
Transferred		
Total	78	42
Ratio	1.85	1.0
Died		
Total	20	7
Ratio	2.85	1.0

CONCLUSIONS

Swyer's[1] discussion of the regionalization of newborn special care facilities in a major metropolitan area (Toronto) disclosed that 1.8% of liveborn infants in 15 different obstetrical units were transferred to a referral center. Individual hospitals varied from 0.5% to 4.6% of deliveries transferred. In the last two years, an average of 1.3% of all babies delivered at St. John's Mercy Medical Center were transferred.

A similar percentage of newborn babies on the "clinic" and private services, respectively, were transferred. This suggests that our "clinic" population may not be typical of "clinic" populations reported from urban centers.

In the babies transferred, pulmonary, prematurity, cardiac and central nervous system disorders accounted for a high percentage of the individual and group morbidity. The sick newborn male is particularly at a disadvantage. This has been discussed by R. C. Naeye[2] and certainly was borne out by the sex ratios of those babies in our series who were transferred and who died.

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ELWYN M. GRIMES, M.D., V. SUMATHY, M.D.
and GERALD L. MILLER, M.D., *Kansas City*

Coexistent Bilateral Tubal Pregnancy

Case Report

Coexisting bilateral ectopic pregnancy is the rarest form of double ovum twin pregnancy. Hakim-Elahi[1] has described five types of multiple tubal pregnancy: (1) Unilateral twin or triplet; (2) bilateral twin with single fetus in each tube; (3) bilateral twin with single fetus in one tube and twins in the other; (4) combined, where a fetus may be present in one or both tubes and in the uterus; and (5) other combinations. In view of the rare occurrence of this condition, a case report of coexistent ruptured interstitial pregnancy in one side and an old unruptured isthmic pregnancy in the opposite tube is presented.

The patient described in this case report was a 28-year-old woman who was found to have a ruptured interstitial pregnancy on the left side coexisting with an old unruptured isthmic pregnancy in the right fallopian tube. Dr. Sumathy is a Fellow in Obstetrics and Gynecology, Dr. Grimes is a Resident and Dr. Miller is Chairman of the Department of Obstetrics and Gynecology, of the Kansas City General Hospital and Medical Center. Dr. Miller also is Clinical Professor at the University of Missouri-Kansas City School of Medicine.

CASE REPORT

The patient, a 28-year-old black woman, gravida 5, para 4, was admitted on June 16, 1972 with a history of amenorrhea for two and one half months. Severe lower abdominal pain had begun during coitus one hour prior to admission. Her menstrual periods had always been regular. She had not used any form of contraception since her last pregnancy five years previously. A history suggestive of pelvic inflammatory disease could not be obtained. There was no history of another recent episode of amenorrhea or menstrual irregularity.

Physical examination revealed a slightly obese, young woman in acute distress. The conjunctivae were pale and extremities were cold and clammy. Her temperature was 38 C. The pulse rate was 100 beats per minute. Blood pressure was 98/60 mm Hg. The heart and lungs were within normal limits except for tachycardia. Abdominal examination revealed generalized tenderness and rigidity that was most intense in both lower quadrants. Pelvic examination revealed the cervix to be soft without dilatation. There was no evidence of bleeding or abnormal cervical discharge. The corpus uteri could not be delineated due to obesity and tenderness. Both adnexal regions were extremely tender and the cul-de-sac of Douglas was noted to bulge. Culdocentesis revealed 20 ml of nonclotted blood.

Laboratory studies revealed a hemoglobin level of 12.6 gm/100 ml; hematocrit reading of 39.2%, white blood cell count (WBC) of 7,800/cu mm with a differential count of 45% neutrophils, 51% lymphocytes and 4% monocytes. A pregnancy test was positive.

An immediate laparotomy revealed approximately 300 ml of old blood in the peritoneal cavity. There was minimal bleeding from a ruptured interstitial pregnancy in the left tube. The entire mass was 3 cm x 3 cm x 3 cm in size and the site of rupture was as shown in Fig. 1. A globular dark nodule 1 cm to 2 cm in diameter was found in the isthmic portion of the right fallopian tube (Fig. 1). A diagnosis of bilateral ectopic gestation was made and a total abdominal hysterectomy with bilateral salpingectomy was performed. The postoperative course was uneventful.

Pathologic examination of resected tissue confirmed an interstitial pregnancy on the left side (Fig. 2). Old hyalinized chorionic villa (ghost villi) with an organizing blood clot was found in the right fallopian tube (Fig. 3).

DISCUSSION

According to Fishback,[2] the criteria for acceptance of a diagnosis of bilateral ectopic preg-

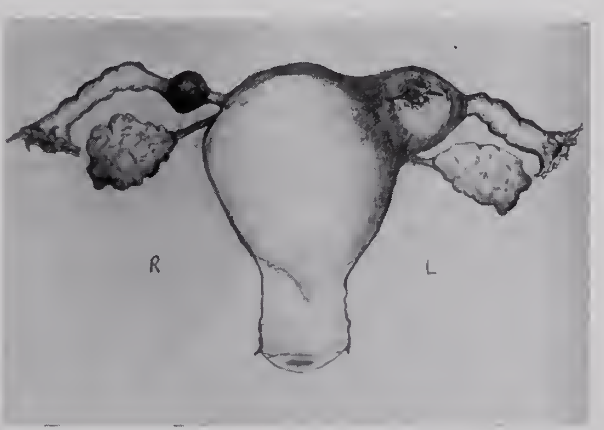

Fig. 1 Drawing of uterus and adnexae shows site of ruptured interstitial pregnancy on the left and location of unruptured isthmic pregnancy in the right tube.

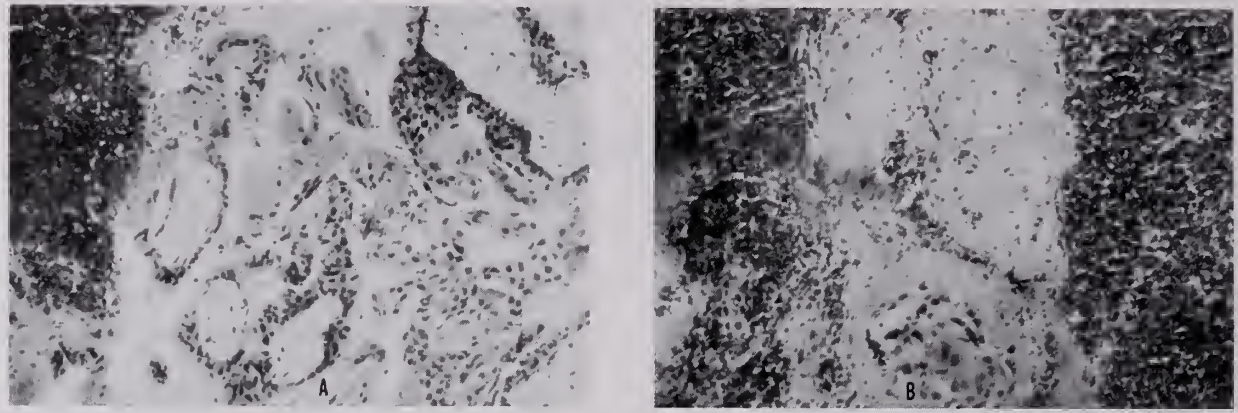

Fig. 2 (A) Normal chorionic villi extruded from site tubal rupture in left tube. (B) Degenerative changes in chorionic villi of left tube.

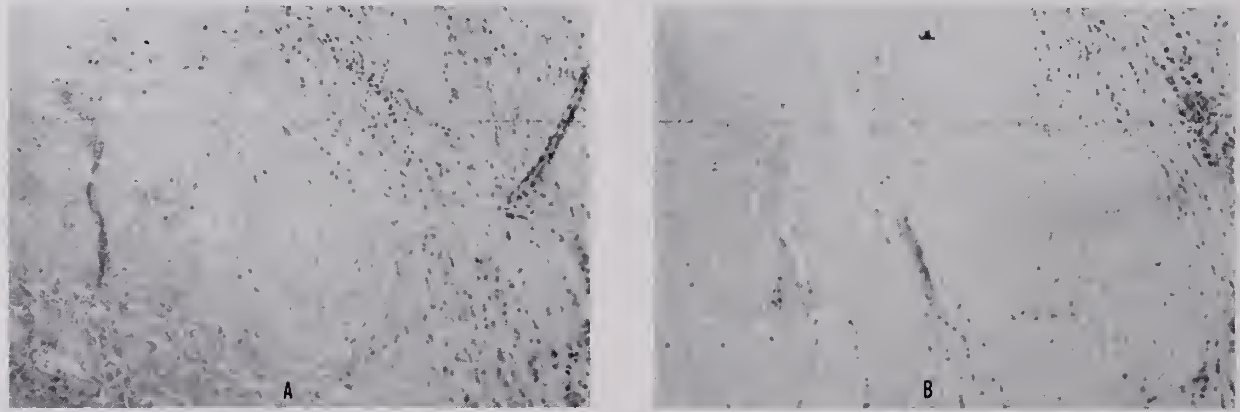

Fig. 3 (A) Ghost villi in wall of right tube adjacent to organizing blood clot. (B) Ghost villi at different site in wall of right tube.

nancy are as follows: (a) description of clinical facts for the particular case, (b) a description of the fetus or any portion of fetus found, (c) a description of placental material found and (d) a microscopic description of resected tissue in regard to gestational age. In the absence of an embryo, chorionic villi must be demonstrated bilaterally by microscopic examination. Decidual reaction is insufficient evidence of ectopic pregnancy, since it may be encountered in the tubes and any other organ in the abdominal cavity during an intrauterine pregnancy.[1]

In 1939, Fishback found 75 cases in the literature which met the above criteria and added an unusual case with three simultaneous tubal pregnancies—two in the right tube and one in the left tube.[2] In 1956, Hoerner collected 33 cases from the literature reported between 1939 and 1954 and added one additional case.[3] In 1965, Hakim-Elahi reported one case and reviewed 39 cases which had been reported between 1954 and 1965.[1] Thus, an overall total of 150 cases of bilateral ectopic pregnancy had been recorded through 1965. The apparent rarity of this condition, as suggested by Weder, Hemstock, and Derechin,[4] could be due to overlooking the second ectopic at the time of operation and lack of reporting isolated cases.

Coexisting bilateral ectopic pregnancy may present in various forms. Stewart[5] reported a case with an unruptured ectopic in one tube and ovarian pregnancy on the opposite side. A case of unruptured bilateral ectopic gestation in the midportion of each tube was reported by Hakim-Elahi in 1956.[3] Burt, Couri and Digiulio[6] reported a case of advanced coexistent bilateral tubal pregnancy with a four-to-five-month fetus in the right tube and a macerated fetus in the left tube. Asriel[7] recorded a bilateral ruptured tubal pregnancy with bilateral corpus luteum cysts in 1969. The most common presentation in most of the reported cases is a ruptured tubal pregnancy on one side and an unruptured old tubal pregnancy on the other side. Our case presented in a similar manner.

According to Stewart,[5] the mortality in bilateral ectopic pregnancy is 3.6%. In the latter review, mortality in most cases was the result of hemorrhage, either acute or delayed. The need for examination of both Fallopian tubes in cases of ectopic gestation is again stressed as has been done repeatedly in the literature.

SUMMARY

A report of an unusual case of coexistent bilateral ectopic pregnancy is presented and the current literature is reviewed. Guidelines for diagnosing and reporting bilateral ectopic pregnancies are stressed.

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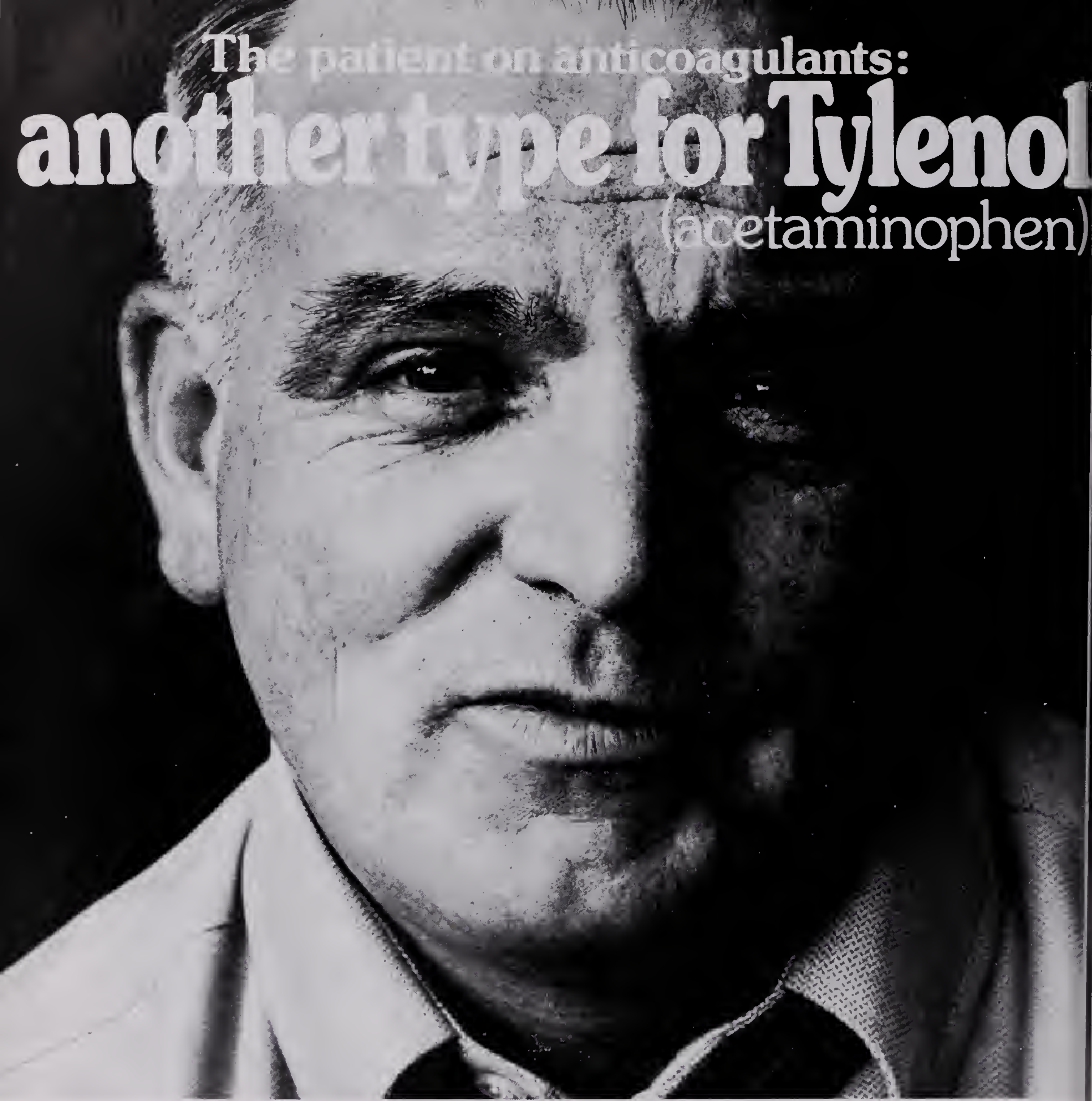

The patient on anticoagulants:
another type for Tylenol
(acetaminophen)

When the patient on anticoagulant therapy has a condition requiring an analgesic, a new problem arises. Aspirin frequently causes prolonged bleeding time and occult gastrointestinal bleeding.[1,2]

TYLENOL (acetaminophen) however, is unlikely to produce either reaction[2,3] and is therefore the preferred analgesic for the patient with hemorrhagic tendencies and the patient receiving anticoagulant therapy.

The patient on anticoagulants is only one of several 'types for TYLENOL'–that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Koch-Weser, J., and Sellers, E.M.: New Eng. J. Med. *285*:447-458 (Sept. 2) 1971. **2.** Udall, J.A.: Clin. Med. 77:20-25 (Aug.) 1970. **3.** Mielke, C.H., Jr., and Britten, A.F.H.: New Eng. J. Med. *282*:1270 (May 28) 1970 (corresp.).

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin,
yet just as effective for relief
of pain and fever

Tylenol®
(acetaminophen)

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President's Message

Know More About Your Medical Association

The Missouri State Medical Association was founded in St. Louis on Nov. 4, 1850 by 136 physicians. It has made steady growth and progress, until it now represents approximately 4,500 doctors—more than 90% of Missouri's practicing physicians.

The MSMA has a newly acquired Headquarters Building in Jefferson City at 113 Madison Street, where members may visit and discuss matters of concern with staff members. The location is very desirable, being just across the street from the Governor's Mansion, two blocks from the State Capitol and within walking distance of most state agencies, an important convenience during the present energy crisis.

E. A. Stricker, M.D.

This proximity also helps the members of the headquarters staff to establish better liaison with members of the General Assembly and Executive Branch in order to express organized medicine's viewpoint on proposed legislation. Also, MSMA members are kept better informed on the many legislative bills pertaining to medicine and health care. The Committee on Legislative Affairs screens all such bills and reports to the MSMA Council and to the House of Delegates. MSMA maintains special liaison with many health-oriented agencies, both governmental and private.

The headquarters staff is ready to assist all members in projects of interest to Missouri physicians. It has the responsibility of informing the public of decisions and policies of the medical profession of this state. Contact with the news media is maintained to insure proper coverage. Scientific news is distributed to members by the green journal, MISSOURI MEDICINE. On July 15 of each year, a Roster Edition listing all members of the Association is published.

MMPAC is a bipartisan and nonprofit organization which is the political arm of the medical profession in Missouri. It is independent of MSMA, and dues are voluntary. The primary objectives of MMPAC are to encourage political activity by physicians and their wives and to support candidates of our choice.

The Woman's Auxiliary to the MSMA is an important force in public relations, political action and all programs to advance medicine and public health in Missouri.

There are many additional benefits offered by the MSMA, such as a free placement service to encourage additional doctors to locate in Missouri and to assist communities in attracting physicians. The MSMA offers three types of insurance programs, which provide substantial savings for its members: they are the Disability Plan, the Major Hospital and Nurse Plan and the Accident plan. A recent addition to the benefits offered is the Educational Tour Program. Approved tours to all parts of the world are offered to members at economical group fares. Medical seminars featuring approved Continuing Medical Education credits compose an important adjunct to the tours. Future plans of the Association call for establishment of a statewide program for Continuing Medical Education.

When you add all the facts and benefits together, it behooves every physician in Missouri to be an active member of his or her Association—to "get involved" in this organization whose functions are entirely to help each physician so that he can better help his patients.

MISSOURI STATE MEDICAL ASSOCIATION

OUR EUROPEAN ADVENTURE IS SWITZERLAND, GERMANY AND AUSTRIA, CHARTERED JETS, DELUXE HOTELS, FRENCH CUISINE, LAKE ZURICH, SWISS WATCHES, KAISER WILHELM CHURCH, THE BRANDENBURG GATE, SNOW-CAPPED ALPS, VIENNESE PASTRY AND $998 PER PERSON.

Europe is yours. Come along for two weeks, we'll see, taste and experience Zurich, Berlin and Vienna

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KANSAS CITY and ST. LOUIS

JUNE 26, 1974

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Enclosed is my check for $ ________
($100 per person as deposit.)

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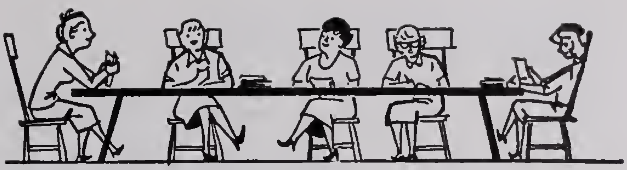
Woman's Auxiliary

50th Anniversary



TEL-E-PROGRAM

Tel-E-Program is the fourth point on our Auxiliary's five-point TEL-STAR program this year. Through Tel-E-Program, we can encourage the wives of members of the Missouri State Medical Association to work within their communities in cooperation with other organizations who share common interests and goals for the good health of their neighbors.

The new programs involved have been revised to keep pace with the times. They are as follows:

1. *Focus on Kids*—Replaces the "Gems and Block Mother" package.
2. *Substance of Abuse*—Pertains to smoking, drug abuse, and smoking and alcohol.
3. *Improving the Quality of Life for the Older American*—Replaces the package program on aging.
4. *Human Sexuality*—Family Life—Emphasizes parent education.
5. *Preparation for Living*—A health education package which includes information on immunization, nutrition and physical fitness.
6. *Blood Donor, Venereal Disease and Health Manpower*—An updated package program.
7. *Mental Health*—Also a new package.
8. *Nutrition and Health Manpower*—These packages are still available.

Mrs. Charles R. Willman
President

Physicians' wives are leaders in an important area. They care, and it is significant that they have that power to determine how they use their ability, time and energy.

As doctors' wives, they choose to be identified with the world of medicine which presents to them opportunities and privileges for showing concern for other people. The Auxiliary is medicine's mechanism which provides membership in an organization in which we can share our interests with our husbands. It also supplies programs as tools for accomplishment and provides pathways for communication necessary to do the job.

Please encourage your wife to be a part of the MSMA Woman's Auxiliary, the organization that cares and has programs available just for the asking. I invite her to write to me at 2105 Lovers Lane, St. Joseph 64505 or to the Woman's Auxiliary of the AMA, 535 N. Dearborn Ave., Chicago, Ill. 60610.

The responsibility for the programs of the medical auxiliaries belongs to all of us. Please share your ideas. Help us to aim high to achieve a superior quality of life for everyone and to contribute something of value to the world.

EDITORIAL

DOCTORS PROTEST 'BIG BROTHER' RULES

WASHINGTON—The practice of medicine in the United States enters a new and ominous phase this week, as Big Brother lays his clammy hand upon physicians across the country.

Henceforth, doctors treating patients under Medicare and Medicaid must submit themselves to Professional Standards Review Organizations.

The doctors have every right to be concerned at the prospect, and their patients should be concerned as well.

Such concepts as "professional standards" and "professional review" of course are not new. Every doctor, before he begins his practice, has to pass a board of medical examiners. If he is attached to a hospital, he regularly faces the judgment and criticism of his peers. For gross mistakes, he is subject to suit for malpractice. His license to practice can be revoked. No doctor operates with untrammeled freedom.

Yet the PSROs involve a new form of regulation and supervision that is different not merely in degree, but in kind.

These organizations, for all practical purposes, are to be agencies of the Federal bureaucracy. To be sure, they will be composed of local physicians, drawn at the outset from local medical societies, but they will be funded by Federal funds and they will be staffed by Federal civil servants.

Until quite recently, little had been heard of the PSRO program. The review plan was authorized under a floor amendment to the Social Security Act of October 30, 1972.

Few members of Congress, eager to get home for elections, paid much attention. No public hearings were held. A considerable time elapsed before doctors discovered the 15 pages of fine type creating an elaborate, nationwide system of local, state and federal review of their professional medical decisions.

Now many doctors belatedly are urging repeal of the PSRO amendment. They make a good case.

Under the law, each of the local PSROs "shall apply professionally developed norms of care, diagnosis, and treatment, based upon typical patterns of practice in its regions."

So long as a doctor stays within these "norms," he stays out of trouble; but if his PSRO disapproves one of his medical decisions, no funds appropriated under Medicare or Medicaid may be disbursed for payment of the particular claim.

The plan is subject to criticism at the outset merely in terms of the paperwork it must entail. In a case of elective surgery, the local PSRO may approve or disapprove in advance of a patient's admission to a hospital.

If a doctor feels his patient should be hospitalized beyond the "norm," he must so certify, and his medical judgment will be reviewed. Agents of each PSRO may inspect a doctor's offices, go over his most confidential patient records, and second-guess his every diagnosis and prescription.

As the *Wall Street Journal* has observed, the doctor who submits to this smothering regulation will have little time left for his patients. The temptation, in any doubtful case, will be to abide by the omnipresent "norm"—to steer clear of innovation, to go strictly by the book.

Perhaps this regimentation will benefit the poor and the elderly. It somehow seems unlikely.

Granted, the controversy has two sides. Medicaid and Medicare constitute a $17 billion drain upon the taxpayers every year. The people have a right to insist on some accountability.

Beyond question, as doctors themselves freely acknowledge, thousands of operations are needlessly performed, and thousands of patients are hospitalized beyond the point at which they might be safely discharged. Why should the taxpayers be soaked for unnecessary expense?

The protesting doctors who have been flooding me with letters of anguish may be suffering a Chicken Little syndrome. Many of them tend to be political hypochondriacs anyhow. The system may not be as bad as they apprehend.

But my own observations of the bureaucratic virus persuade me that the PSRO plan is a wasting disease, insidious and destructive, demeaning and degrading. And sad to say, the bureaucratic disease is easy enough to diagnose, but almost impossible to cure.

JAMES J. KILPATRICK

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Welcome, New Members!

April 4-7, 1974

MSMA 116th ANNUAL SESSION

Crown Center Hotel
Kansas City

County Society News

FIRST DISTRICT
COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

The first meeting of the New Year of the Buchanan County Medical Society was held on January 2 in the Empire Room of Hotel Robidoux. Forty-three persons attended the dinner and meeting.

Dr. Randal W. Weed, newly-installed President of the Society, presided. Dr. Edward M. Beheler, Program Chairman, introduced the panelists for a discussion of "Pension and Profit Sharing, Tax Shelters and Estate Planning as They Affect the Physician."

Mr. James R. Bocell, senior vice-president and senior trust officer of the American National Bank, moderated the discussion. Other participants were Mr. O. W. Watkins, Jr., attorney with Strop, Watkins, Roberts and Hale; Mr. Davis A. Beaver, C.L.U. with the Connecticut Mutual Life Insurance Co.; and Mr. R. Eugene McGannon of Kansas City, an attorney with Hoskins, King, McGannon, Hahn and Hurwitz.

Each participant discussed the topic from the point of view of his specialty and a lively question-and-answer period session followed the program.

John T. Rogers, M.D., *Secretary*

SECOND DISTRICT
COUNCILOR
LYSLE M. BACH, M.D., HANNIBAL

Chariton-Macon-Monroe-Randolph County Medical Society

The Chariton-Macon-Monroe-Randolph County Medical Society met on December 13, 1973 in the Woodland Hospital Library in Moberly.

Members present were Drs. J. E. Campbell, Gretchen Collins, D. E. Eggleston, F. A. Barnett, J. Baker, R. Bautista, W. D. Chute, C. C. Cohrs, P. V. Dreyer, T. S. Fleming, L. E Huber. G. R. Hudson and R. V. Tompson. Guests were Dr. Leopold Lachance of Centralia, Miss Caroline Murr of Macon and Paul C. Collins, Ph. D. of Macon.

Dr. Tompson presented several communications from the American Medical Association and Missouri State Medical Association.

The program was presented by Paul Collins, Ph.D. Dr. Collins, a native of Moberly and a pastor in the Methodist Church, also is engaged in Macon as a full-time private counselor. He spoke on various aspects of counseling and how it can augment medical therapy, various aspects of marital counseling and family interpersonal relations and theological interplay and individual emotional disturbances. He presented several case histories.

A question and answer period followed.

Robert V. Tompson, M.D., *Secretary*

LETTERS to the Editor

The Editor
Missouri Medicine

This is a progress report of a study conducted by the ENT and Neurology Departments, Washington University, between April, 1972 and September, 1973. Twenty-seven of 120 patients with facial paralysis were considered eligible for a prognostic, natural history and therapeutic study.

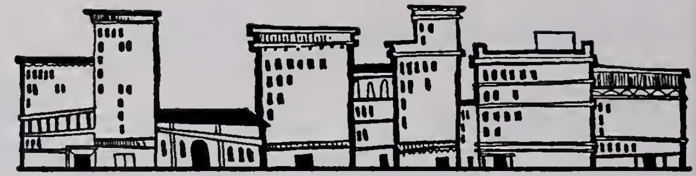
The study indicates that the poor-risk patients, who are those likely to have incomplete return, can be selected within 48 hours of onset, based upon testing salivary flow. In addition, the data suggest that corticosteroid therapy may not alter the natural history. The final conclusion regarding the efficacy of these steroids will require an additional 40 patients to have statistical significance.

In our judgment, with the help of the primary physician, this study can be completed within the next year. All of us need to know if corticosteroids have any value in treating patients with Bell's palsy. Cooperation by referring patients to be included in this study would be sincerely appreciated. This study will be successful only with the help of physicians.

Physicians are invited to call 314-454-3055, or in the evenings and on weekends, call Dr. Mark May at home, 314-432-2335. There will be no charge and all patients will receive treatment only after consultation with the referring physician. As in the past, periodic progress reports will be forwarded to the referring doctor.

Mark May, M.D.
Department of Otolaryngology
Washington University
St. Louis, Mo. 63110

From the Medical Schools



ST. LOUIS UNIVERSITY

St. Louis University has announced tuition increases of $75 per semester in most schools of the University for the 1974-1975 academic year. School of Medicine tuition increased from $1,350 to $1,425 per semester. In a letter to University students and parents, the *Rev. Paul C. Reinert, S.J.*, University president, said, "Steadily rising costs made it impossible to avoid a tuition increase for the next academic year." He added that the effects of inflation have been "particularly severe" on colleges and university campuses across the country.

In recent months, members of the Department of Biochemistry have received grants or contracts. Principal investigators and their awards are *Dr. Max K. Horwitt,* professor of biochemistry, $58,500, a one-year award from the National Institutes of Health for a contract to study the effect of oral contraceptives on nutritional status and a one-year award from Hoffmann-LaRoche to support research on erythrocyte stability in extra-corporeal pump circulation; *Dr. William J. Longmore,* $88,000 a year investigation from the National Institutes of Health for the investigation of the regulation of lipid metabolism in the lung; and *Dr. Barry L. Marrs,* a $40,000 award from the National Science Foundation for a 2½-year period for a study of energy metabolism of bacterial membranes.

Four new instructors at the St. Louis University School of Medicine have been announced. They are *Joseph Giangiacomo,* M.D., instructor in pediatrics; *Barbara J. Hebert,* M.P.H., instructor in community medicine; *Katherine E. Jacobs,* M.D., instructor in psychiatry; and *Pochin H. Yin,* bachelor of medicine, instructor in pediatrics.

Dr. Jerome T. Y. Shen, associate clinical professor of pediatrics, has been named by the National Academy of Pediatrics as liaison representative to the annual conference of the National Council of Juvenile Court Judges.

Dr. Denis Cavanagh, chairman, Department of Gynecology and Obstetrics, was reelected to the executive committee of the American College of Obstetrics and Gynecologists.

UNIVERSITY OF MISSOURI-COLUMBIA

Academic departmental status has been granted to Neurology, formerly a division of the Department of Medicine at the University of Missouri-Columbia School of Medicine.

The MU Board of Curators approved the change at its November, 1973 meeting. *Dr. Harry H. White* has been appointed by Chancellor Herbert Schooling as the chairman of the new department.

Dr. White joined the Missouri faculty in July 1972. He is a graduate of the University of Kansas Medical School and received specialty training at the Neurological Institute of New York, associated with Columbia University.

He is certified by the American Board of Psychiatry and Neurology in both neurology and child neurology. He was on the faculty at the KU Medical School from 1964 to 1972. His primary research interests are in genetically-determined diseases of the nervous system and inborn errors in metabolism.

The department is involved in teaching third- and fourth-year medical students and in training residents and interns in the departments of medicine, surgery and psychiatry. Residents in family practice also are expected to go into the neurology training program in the near future.

Gwilym S. Lodwick, M.D., professor and chairman of the Department of Radiology, has been recognized for his outstanding contributions to his field by being awarded the gold medal of the XIII International Congress of Radiology. Announcement was made this week by *Dr. Juan Gomez Lopez* of Spain, president of the organization.

A pioneer in computer applications in this medical field, Dr. Lodwick has previously been honored by Sigma Xi scientific society on the University of Missouri campus and by his alma mater, the University of Iowa College of Medicine. Another recent recognition came with his biographical sketch in "Who's Who in the World," 1974 edition.

Dr. Lodwick was one of the invited speakers at the International Congress of Radiology in Madrid last October. He is noted for his work in developing computer-assisted diagnosis of bone tumors and, more recently, development of a computer program for automated diagnosis of heart and lung disease. He was largely responsible for inaugurating inter-disciplinary bioengineering programs on the Columbia campus of the University.

A second group of five volunteers began a 16-week planned diet sequence on January 14 to aid in a University of Missouri study on the possible relationship of a high meat diet and cancer of the colon.

Cancer of the colon is the second most common cause of death from cancer in the United States today. In less Westernized societies, the disease occurs far less. Because of this difference, it is logical that diet should come under review, researchers believe.

The Missouri study, sponsored by the National Cancer Society, seeks to determine the composition of the anaerobic bacterial flora and the concentrations of potentially carcinogenic substances present in the feces of persons on a high meat diet.

The year-long inter-disciplinary study combines the expertise of investigators from several departments on the Columbia campus of the University, including microbiologists, biochemists, chemists, a gastroenterologist, a nutritionist and a statistician.

Dr. David Hentges presented a progress report on the study at a recent collaborative conference of the National Cancer Society in San Antonio, Tex. He is professor of microbiology and research project director.

WASHINGTON UNIVERSITY

Dr. Gordon W. Philpott, associate professor of surgery at the School of Medicine, has been appointed assistant dean for curriculum at the school.

He succeeds *Dr. Richard W. Hudgens*, who is entering private practice but will remain on the faculty as associate professor of clinical psychiatry.

Dr. Philpott received his pre-clinical education at Yale University and was graduated cum laude in 1961 from Washington University School of Medicine. He received his graduate surgical training at Barnes Hospital. He joined the Washington University faculty in 1968.

The Allen P. and Josephine B. Green Foundation's recent gift of $35,000 to Washington University School of Medicine was final payment of a $500,000 pledge to support pediatric neurology.

The Foundation, located in Mexico, Mo., presented the check to *Philip R. Dodge, M.D.*, professor of pediatrics and of neurology, who is head of the Edward Mallinckrodt Department of Pediatrics and medical director of St. Louis Children's Hospital.

MSMA MEMBERS!

Watch for Your Special Hotel Reservation Card!

For the convenience of members who plan to reserve rooms at the Crown Center Hotel, the MSMA will mail a special, postage-paid reservation card with room rates and other pertinent information.

You should receive your reservation card this month. Please forward it to the hotel as soon as possible for best accommodations.

MISSOURI STATE MEDICAL ASSOCIATION

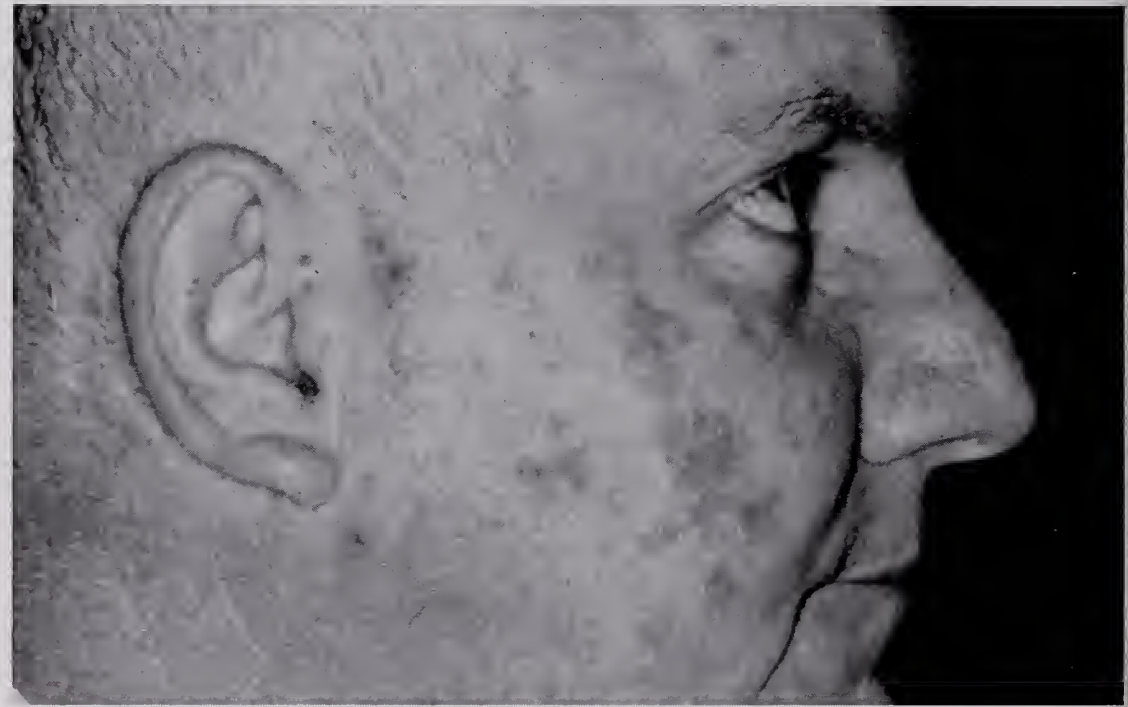
116th ANNUAL SESSION

April 4-7, 1974 Crown Center Hotel, Kansas City

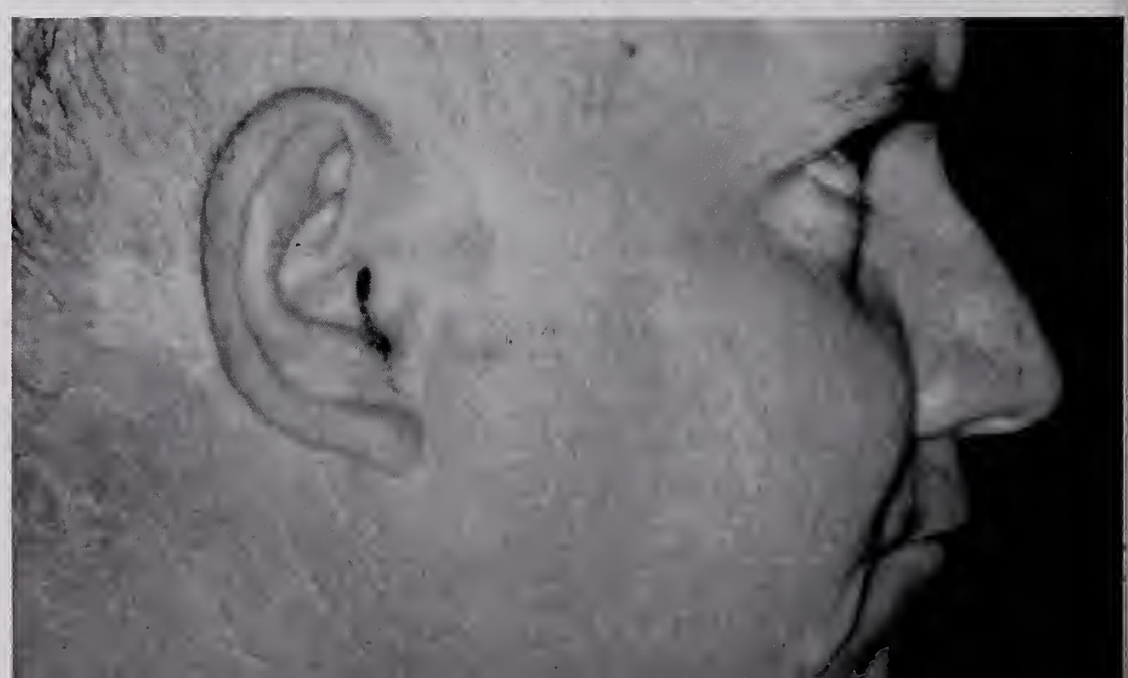
What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.



*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic– so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteris-ics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple esions, chiefly on the exposed portions of the skin.

Sequence of therapy– selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.
Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

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New Members

Avrora M. Amin, M.D., 5400 Arsenal, St. Louis, has become a member of St. Louis County Medical Society. Dr. Amin is a native of Argentina, received her preliminary education at Esguela Normal and her M.D. degree at Buenos Aires University in 1961. She specializes in psychiatry.

Chung-Kuang Chen, M.D., 5341 Arsenal, St. Louis, has become a member of St. Louis County Medical Society. Dr. Chen is a native of Taiwan, received his preliminary education at Kaohsiung Medical College and his M.D. degree at Kaohsiung Medical College in 1969. He specializes in psychiatry.

Arabinda Das, M.D., 110 North High, Belleville, Ill., has become a member of St. Louis County Medical Society. Dr. Das is a native of Champatipur, India, received his preliminary education at Puri College and his M.D. degree at Sriram Chandra Bhanj Medical College in 1955. He specializes in neuro-psychiatry.

Sami B. Elhassani, M.D., 1206 Swifts Highway, Jefferson City, has become a member of Cole County Medical Society. Dr. Elhassani is a native of Baghdad, Iraq, received his preliminary education at Baghdad College and his M.D. degree at the University of Baghdad in 1959. He specializes in pediatrics.

Edgardo C. Francisco, M.D., Nevada State Hospital, Nevada, has become a member of West Central Missouri Medical Society. Dr. Francisco is a native of the Philippines, received his preliminary education at Manila Central University and his M.D. degree at Manila Central University in 1964. He specializes in adult and child psychiatry.

L. E. Giffen, D.O., 420 E. High, Jefferson City, has become a member of Cole County Medical Society. Dr. Giffen is a native of Jefferson City, received his preliminary education at Lincoln University and his M.D. degree at Kirksville College in 1945. He specializes in family practice.

Gordon M. Goldman, M.D., 216 S. Kingshighway, St. Louis, has become a member of St. Louis County Medical Society. Dr. Goldman is a native of Toledo, Ohio, received his preliminary education at Toledo University and his M.D. degree at St. Louis University in 1966. He specializes in obstetrics and gynecology.

Chuong Chun Huang, M.D., 5400 Arsenal, St. Louis, has become a member of St. Louis County Medical Society. Dr. Huang is a native of Formosa, received his preliminary education at National Taiwan University and his M.D. degree at National Taiwan University in 1962. He specializes in psychiatry research.

Roberto Lopez-Plata, M.D., 1815 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Lopez-Plata is a native of Bogota, Colombia, received his preliminary education at National College of San Bartolome and his M.D. degree at National University of Colombia in 1958. He specializes in general surgery.

Herbert L. McDonald, M.D., 6700 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. McDonald is a native of Granite City, Ill., received his preliminary education at the University of Missouri-Columbia and his M.D. degree at the University of Missouri-Columbia in 1959. He specializes in thoracic surgery.

Angus Macleod, M.D., 10037 Elise, St. Louis, has become a member of St. Louis County Medical Society. Dr. Macleod is a native of Romford, England, received his preliminary education at John Watsons School and his M.D. degree at Glasgow University in 1967. He specializes in internal medicine.

David S. Meyers, M.D., 806 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Meyers is a native of Grand Rapids, Mich., received his preliminary education at Michigan State University and his M.D. degree at the University of Michigan in 1972. He specializes in pathology.

George Pelican, M.D., 649 S. New Ballas Rd., St. Louis, has become a member of St. Louis County Medical Society. Dr. Pelican is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at the University of Athens in 1969. He specializes in internal medicine.

Elson F. Seitz, M.D., 1509 W. Truman Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Seitz is a native of Hutchinson, Kan., received his preliminary education at Kansas State University and his M.D. degree at the University of Kansas in 1963. He specializes in pathology.

A. V. Sicat, M.D., 1433 Southwest Blvd., Jefferson City, has become a member of Cole County Medical Society. Dr. Sicat is a native of Manila, Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1964. He specializes in orthopedic surgery.

Robert C. Silvers, M.D., 729 Cherry Tree Lane, Olivette, has become a member of Boone County Medical Society. Dr. Silvers is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at the University of Missouri-Columbia in 1970. He specializes in neurology.

Boyd E. Terry, M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. Terry is a native of St. Anthony, Idaho, received his preliminary education at the University of Idaho and his M.D. degree at Washington University in 1957. He specializes in general surgery.

John W. Wally, M.D., 44th and Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Wally is a native of Kansas City, received his preliminary education at Stanford University and his M.D. degree at the University of Kansas in 1968. He specializes in general practice (emergency).

Fazle Mobin Yasin, M.D., 5400 Arsenal, St. Louis, has become a member of St. Louis County Medical Society. Dr. Yasin is a native of Delhi, received his preliminary education at D. J. Science College and his M.D. degree at Dow Medical College in 1964. He specializes in psychiatry.

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In Memoriam

Martin M. Hart, M.D., 2nd and Washington, Salem, a graduate of St. Louis University, 1943; member of Mid-Missouri County Medical Society; age 55; died Nov. 14, 1973.

Alfred Goldman, M.D., 1200 Hampton Park Dr., St. Louis, a graduate of Washington University, 1920; member of St. Louis Medical Society; age 78; died Nov. 25, 1973.

Leonard P. Stein, M.D., 2618 Oregon Ave., St. Louis, a graduate of Heidelberg University, 1929; member of St. Louis County Medical Society; age 77; died Nov. 28, 1973.

Harvey P. Boughnou, M.D., 4545 Wornall, Kansas City, a graduate of St. Louis University, 1913; member of Jackson County Medical Society; age 85; died Dec. 8, 1973.

Paul N. Johnstone, M.D., Bryant Bldg., Kansas City, a graduate of Johns Hopkins University, 1926; member of Jackson County Medical Society; age 73; died Dec. 11, 1973.

Melvin O. Langhus, M.D., 104 W. Englewood Rd., N. Kansas City, a graduate of the University of Wisconsin, 1937; member of Clay County Medical Society; age 68; died Dec. 11, 1973.

Armand C. Forster, M.D., 700 W. Essex, St. Louis, a graduate of St. Louis University, 1934; member of St. Louis Medical Society; age 64; died Dec. 12, 1973.

W. A. Bloom, M.D., 300 N. Church St., Fayette, a graduate of the University of Ohio, 1925; member of Howard County Medical Society; age 75; died Dec. 22, 1973.

Harold Unger, M.D., 601 E. 63rd, Kansas City, a graduate of Ohio State University, 1935; member of Jackson County Medical Society; age 63; died Dec. 22, 1973.

John S. Knight, M.D., 2900 W. 53rd, Shawnee Mission, Kan., a graduate of the University of Pennsylvania, 1925; member of Jackson County Medical Society; age 72; died Dec. 23, 1973.

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LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

The State Board of Health reelected its officers at a meeting in Jefferson City on January 16. The officers are Dr. Emmett P. North, St. Louis, president; Dr. P. T. Bohan, Kansas City, vice-president; and Dr. E. T. McGaugh, Richmond, secretary.

Dr. Frank R. Teachenor, Kansas City, was elected president of the Western Surgical Association at the annual meeting in Cincinnati recently. Dr. Thomas G. Orr, Kansas City was reelected treasurer.

The Barnard Free Skin and Cancer Hospital in St. Louis received a bequest by the terms of the will of the late Mrs. Mary L. Barnard. The hospital was founded by her late husband, Mr. George D. Barnard. Mrs. Barnard made several other bequests in her will and the rest of the estate was left to the hospital. She had made yearly contributions to the hospital since the death of her husband in 1916.

Approximately 1,000 physicians are cooperating with the Municipal Health Division of the St. Louis Health Department in a campaign to bring diphtheria under control, according to Dr. Paul J. Zentay, assistant health commissioner.

TWENTY-FIVE YEARS AGO

The 91st Annual Session of the Missouri State Medical Association will be held in Kansas City on March 27-30 in the Municipal Auditorium. Luncheon and dinner meetings will be held at the Hotel President.

The average age of physicians in the United States is slightly less today than it was at the outbreak of World War II. The median age of the 199,745 doctors of the nation is 44.4 years. In 1940, the median age for 175,146 doctors was 45.8 years. The percentage of all physicians less than 50 years of age rose from 57.5 in 1940 to 60.2 in 1948. In the age group of 35 to 49, the percentage rose from 31.4 to 36.5. "The medical population has increased 14% since 1940 while the total population of the country increased only 12%." The number of physicians and their median age for each state is as follows: Kansas, 2,206—46.6 years; Missouri, 5,345—47.5 years; New York, 30,981—43.8 years.

Vilray P. Blair, M.D., St. Louis, was guest of honor at a meeting of the American Society of Plastic and Reconstructive Surgery at White Sulphur Springs, Va. and was presented a certificate.

Emma Arabella Thompson, M.D., Breckenridge, was honored by her community on November 5 for her many years of service as a physician.

Dr. Frank D. Dickson, Kansas City, is in charge of the local committee on arrangements for a sectional meeting of the American College of Surgeons to be held in Kansas City on February 11-12.

Dr. Robert E. Schlueter was made Honorary Librarian for Life of the St. Louis Medical Society at the annual meeting of the Society held on January 4.

TEN YEARS AGO

The medical staff of St. Mary's Hospital, Jefferson City, recently elected Landon H. Gurnee, M.D. as president; Francis X. Meier, M.D., vice-president; and William A. Cox, secretary-treasurer. Dr. John I. Matthews and Dr. Julian A. Ossman were elected to the staff's executive committee.

At a meeting in Springfield, the Southwest Missouri Chapter of the American College of Surgeons elected Michael J. Clarke, M.D., Springfield, president; Dale Alquist, M.D., Joplin, vice-president; and F. Thomas Mosely, M.D., Springfield, secretary-treasurer.

Newly elected officers of the staff at St. Vincent's Hospital in Monett are Drs. Mary J. Newman, Cassville, president; A. J. Graves, Mount Vernon, vice-president; and F. L. Edwards, M.D., Monett, secretary.

Ben H. Senturia, M.D., St. Louis, was elected chairman of the Section of Otolaryngology at a recent meeting of the Southern Medical Association.—A new member of the board of directors of the American Rhinologic Society is Pat A. Barelli, M.D., Kansas City.

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116th MSMA Annual Session
April 4-7, 1974 Kansas City

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MSMA NEWS ROUND-UP

MARCH, 1974

PSRO, fees, politics, CME

'Lively' Annual Session likely

The supurb scientific program which always highlights the Annual Session of the Missouri State Medical Association is planned again this year — but the scientific program may have to share the limelight with a flood of socioeconomic and political issues which physicians are currently facing.

The 116th Annual Session will be held April 4-7 at the new Crown Center Hotel in Kansas City. MSMA members have received a Preliminary Program and a hotel reservation card.

Two of Missouri's top political figures, Gov. Christopher S. Bond and State Senator William J. Cason, will address physicians at the Session. Also scheduled to speak at the meeting are John M. Chenault, M.D., member of the AMA Board of Trustees, and Holman R. Wherritt, M.D., Regional Health Administrator for the Department of HEW.

"PSRO", "Discriminatory Fees", "Seat Belt Legislation", "Hospital Medical Staff Affairs", "Establishment of a MSMA Liability Insurance Group" these are just a few of the 39 resolutions already submitted for consideration by the House of Delegates. Many others, including several which would affect the internal structure of the MSMA, will come before the House.

Gov. Christopher S. Bond

Sen. William J. Cason

A new feature of the Annual Session will be a "Speak Out to Your AMA Delegates" session planned for 9:30 to 11:30 a.m., Saturday, April 6, in the Independence Room at the hotel. The session will be informal with Missouri's four AMA Delegates and four Alternates on hand to answer questions and listen to opinions concerning AMA matters.

Gov. Bond will be the guest speaker at the Past President's Banquet, at 6:30 p.m., Saturday, April 6. Sen. Cason, of Clinton, President Pro Tem of the Senate, will address the MSMA-MMPAC General Luncheon at 12:45 p.m., Saturday, April 6.

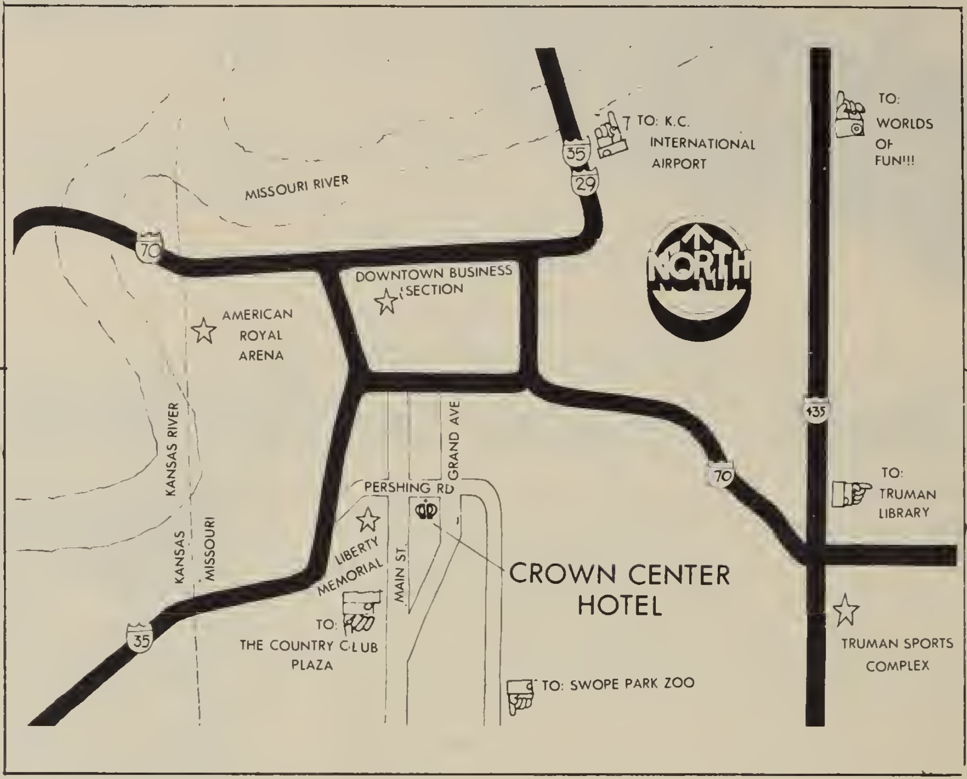
Gov. Bond who was elected to that office in 1972, is the first Republican to be elected Governor of Missouri since 1940. Thirty-four years old, Bond is the youngest Governor in the nation and the youngest Governor in the history of Missouri.

Sen. Cason, an attorney, has represented the 31st Senatorial District for 13 years and served as Democratic Majority Floor Leader for two years prior to being elected President Pro Tem. He is widely considered the leading contender for the Democratic nomination for Governor in 1976.

Preceding Gov. Bond's talk, James C. Cope, M.D., of Columbia, will be installed as 1974 President of the MSMA, succeeding E. A. Stricker, M.D., of St. James. Also at the Banquet, Past Presidents of the Association, 50 Year Members

See next page

The map below shows access routes to Crown Center.



Bond, Cason to speak at Session, April 4-7

Continued

and three news media representatives will be honored.

Tickets for the Banquet and Luncheon will be available at the MSMA Registration Desk in the hotel.

Scientific and Economic topics of interest to all Missouri Physicians are scheduled during the 116th Annual Session.

The scientific session will offer physicians a wide choice of programs on a variety of topics. Several medical specialty organizations will sponsor continuing medical education programs and some of the speciality groups are holding annual meetings in conjunction with the MSMA.

The scientific program has been approved for 11 elective hours of Continuing Medical Education by the American Academy of Family Physicians.

Scientific sessions are scheduled all day Friday and Saturday, April 5-6. "PSRO" will be the subject at the opening General Session at 9 a.m. Friday. Speakers will be Dr. Chenault, Decatur, Ala., and Dr. Wherritt, Kansas City.

The House of Delegates will meet at 1:30 p.m., Thursday, April 4; at 4 p.m., Friday, April 5, and at 7:30 a.m., Sunday, April 7.

The Woman's Auxiliary to the MSMA is planning a full program in observance of its 50th Anniversary. Members and non-members of the Auxiliary are invited to attend the functions.

MSMA asks end to physician price controls

The Missouri State Medical Association has requested that physicians be removed from mandatory wage and price controls by the Federal Cost of Living Council.

The Nixon Administration has asked Congress to continue wage-price controls on medical and health professions until a national health insurance bill is passed.

The 4 per cent limit placed on physicians (See December MISSOURI MEDICINE) expires April 30. Congress must decide what to do before that time.

In a telegram to Missouri's two U.S. Senators, E. A. Stricker, M.D., President of the MSMA, explained that physicians have held their fees within or below allowable federal regulations since controls were initiated in 1971. Under Phase 3, in January 1973, most of the economy was released from controls, but discriminatory regulations were continued on physicians.

"Costs to physicians are rising without regulation," stated Dr. Stricker, "while physicians' income is controlled."

Dr. Stricker also pointed out that since controls began, physicans' fees have risen only 7.3% while the cost of living generally has risen 13.3%.

The Nixon proposal to extend the limitations is being heard before a Senate Committee. Copies of the telegram were mailed to Missouri's members of the U.S. House of Representatives.

Dr. Cope to take MSMA reigns

E. A. Stricker, M.D.
President

James C. Cope, M.D.
President-Elect

James C. Cope, M.D., of Columbia, will become President of the Missouri State Medical Association on Saturday night, April 6, during banquet ceremonies at the 116th Annual Session in the Crown Center Hotel, Kansas City.

Dr. Cope, a urologist, will receive the gavel from outgoing MSMA President, E. A. Stricker, M.D., of St. James.

Gov. Christopher S. Bond will be the featured speaker at the Annual Banquet honoring Drs. Cope and Stricker. Other highlights of the banquet include the recognition of Past Presidents of the Association, presentation of awards to 50-year members and the announcement of MSMA News Media Awards.

Dr. Cope has served eight years as MSMA Fifth District Councilor and is Immediate Past-Chairman of the MSMA Council. He is a Past President of the Boone County Medical Society, a member of the American Medical Association, the Missouri Federation of Urologists and the American Urological Association.

He is active on the staff of the Boone County Hospital, is Associate Clinical Professor of Urological Surgery at the University of Missouri School of Medicine, and is a urology consultant at the Ellis Fischel Cancer Hospital.

Dr. Cope received his undergraduate training at William Jewell College, his M.D. degree at New York University and his B.S. and M.A. degrees at the University of Missouri.

Opinions asked on specialty representation in AMA

Should National Medical Specialty Societies have direct representation in the AMA House of Delegates?

The Council on Constitution and Bylaws of the AMA has been charged with studying a proposal to grant specialties direct representation and is conducting an investigation before reporting to the AMA House of Delegates in June.

The Council has requested that state associations make known to their membership the following questions so that each AMA member can provide his personal opinion on the matter. The questions are:

(1) What effect would direct representation for Medical Specialty Societies have on the Federation concept, upon which AMA is based?

(2) What effect would such representation have on the Scientific Assembly of the AMA?

(3) What effect would such representation have on the membership of all medical societies involved: the AMA, State Medical Associations, County Medical Societies and Medical Specialty Societies?

(4) What effect would such representation have on the activities and influence in the community of the State and County Medical Societies?

MSMA members should address their correspondence to:

Council on Constitution and Bylaws
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

MSMA Council protests pre-admission certification

A strongly-worded protest to proposed HEW regulations which would have required pre-admission certification for Medicare and Medicaid patients was approved at the February meeting of the MSMA Council.

The Council's letter of protest was sent to the Administrators of Medicare and Medicaid, the entire Missouri Congressional Delegation and to Gov. Christopher Bond on Feb. 2. The letter urged that the proposed regulations be "promptly and permanently rescinded."

On Feb. 5, Casper Weinberger, Secretary of HEW, issued a statement that he will not pursue the controversial pre-admission certification proposal. Organized medicine, from local medical societies through the AMA, flooded HEW with objections to the proposal.

In other actions, the Council:

- Recommended the reappointment of Joseph V. Finnegan, M.D., as Editor of MISSOURI MEDICINE.
- Endorsed Joseph White, M.D., Provost for Health Affairs at the University of Missouri-Columbia, for re-election to the AMA Council on Medical Education.
- Encouraged all MSMA members who can possibly do so, to attend the AMPAC Workshop, March 15-17, in Washington, D.C.
- In an opinion requested from AMA, recommended that intern and resident membership in the AMA be made through regular channels — local and state societies.
- Requested the AMA to make available material showing the difference between the Nixon Administration and Medicredit national health insurance bills. This material will be printed in MISSOURI MEDICINE.
- *Established an Ad Hoc Committee to meet with the Missouri Division of Insurance concerning the problem of rising premium costs for malpractice insurance.*
- Accepted the report of the Voluntary Health Agency Committee and recommended that a list of voluntary agencies be published in the directory issue of MISSOURI MEDICINE.
- Heard a report from AMA that Missouri had a gain of about 90 AMA members during 1973.
- Established an Ad Hoc Committee on Family Planning to work with the Division of Health. Committee members are Drs. Louis Hetlage, Robert Bregant and John Martin.
- Approved the planning for a Management Workshop to be held in St. Louis, May 5-6. The program will be to aid senior residents about to enter private practice.
- Heard a detailed report on many of the more than 100 health-related bills before the current Missouri General Assembly.

Speaker's seminar held

Over 30 members of MSMA and MMPAC took part in the AMA's Leadership Speaker's Training Seminar, Feb. 23-24, in Jefferson City.

Mort Enright, director of AMA's Speakers Division, conducted the course with assistance from Robert Lang, Ph.D., Cleveland Academy of Medicine, T. Stephen May, Ph.D., Northwestern University School of Speech, and Russell Miller, JD, Professional Parliamentarian.

Participants were required to write and deliver a three-minute speech which was filmed on vidio-tape. The tape was later replayed before the entire group and the speaker was required to defend the position he stated in the speech.

Comments from participants indicated that the seminar was one of the most enlightening and productive medical programs many had attended.

News in Brief

Gasoline situation

There have not been any reports of physicians having trouble obtaining gasoline to date, but MSMA Headquarters has already discussed the possible situation with the Missouri Fuel Allocation Board.

Tom Wade, head of the board, said he does not foresee rationing in Missouri. He said that under present conditions, physicians are in the same situation as other drivers in the open market — buy it where you can find it.

After studying plans in states where gas rationing is in effect, it is probable that should Missouri begin rationing, physicians would most likely be classed as "commercial users." Under that classification, physicians would be eligible for a higher allotment of gasoline than others.

If proposed regulations are altered, you will be kept informed through MSMA Headquarters.

Write your Senator

Physicians are urged to write their congressmen and senators asking an end to the Economic Stabilization Act. The law is scheduled to expire April 30 unless extended by Congress.

Continuation of Phase 4 controls is unlawful, the American Medical Association contends, and extension of controls solely on MDs would violate the Constitution.

Physicians should write their own congressmen and senators, with copies to Sens. John Sparkman (D., Ala.) and John G. Tower (R., Tex.), ranking members of the Senate Committee on Banking, Housing, and Urban Affairs, which is considering extension of the ESA act.

Copies should also be sent to the House Banking and Currency Committee and to the MSMA Headquarters.

New TV show set

The AMA has announced a new television series titled "Today's Health," a weekly half-hour series designed to explore varied aspects of health and medicine.

"Today's Health" will be co-hosted by Norman Pastorek, M.D., who teaches at the New York Hospital-Cornell Medical Center and is in practice in New Rochelle, N.Y., and Ms. Carlin Glynn, an active participant in a consumer action group, "Consumer Action Now."

"Today's Health" is being distributed through television stations on a trade basis beginning in April.

It is hoped that 60-100 TV stations with an estimated audience of 7 million will schedule the show.

MISSOURI STATE MEDICAL ASSOCIATION

113 Madison St., P. O. Box 1028, Jefferson City, Mo. 65101
Telephone: AC 314-636-5151

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Vice-Speaker, James T. Brown, M.D., Springfield

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J. Loren Washburn, M.D., Versailles
Rae W. Froelich, M.D., Lebanon, *Alternate*
Hector W. Benoit, Jr., M.D., Kansas City
Hugh E. Stephenson, Jr., M.D., Columbia, *Alternate*
Arthur W. Neilson, M.D., St. Louis (Deceased)
Robert W. Kelley, M.D., St. Louis, *Alternate*
Hubert A. Ritter, M.D., St. Louis
Lawrence W. O'Neal, M.D., St. Louis

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Executive Assistant, Thomas P. Fox
Assistant Executive Secretary, Royal O. Cooper
Public Relations Director, C. C. Swarens

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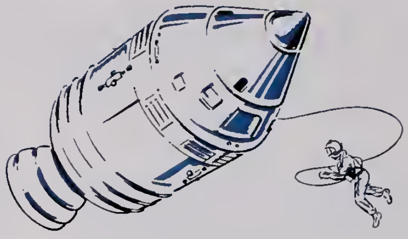

Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

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Dosage:

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2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

Preliminary Program
116th Annual Session

MISSOURI STATE MEDICAL ASSOCIATION

Crown Center Hotel, Kansas City **April 4-7, 1974**

Thursday, April 4

11:00 AM Registration of Delegates.
1:30 PM House of Delegates Meeting, opening session.
3:30 PM Reference Committee Meetings.
6:30 PM Missouri State Surgical Society Executive Council Meeting, Buttonwood Tree Inn, London Room, 4800 Main.

Friday, April 5

8:00 AM Registration.
9:00 AM General Session. *Professional Standards Review Organization (PSRO).*
Introduction: E. A. Stricker, M.D., St. James, MSMA President.
Speakers:
John M. Chenault, M.D., Member, Board of Trustees, American Medical Association.
Holman R. Wherritt, M.D., Regional Health Administrator, Region VII, Department of Health, Education and Welfare, Kansas City.
10:30 AM Intermission to view exhibits.
10:30 AM Presiding: Clarence C. Cohrs, M.D., Moberly, President, Missouri State Allergy Association.
Participants:
Association Between Learning Disorders, Behavior Disorders and Allergy, James Hartwright, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
The Antigenic Deterioration Rate of Aqueous Ragweed Pollen Extracts, Josephine G. Brunidor, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
The Dual-Based System of Immunity, Norman T. Berlinger, M.D., New York, N. Y., Fellow, Clinical Immunology Service, Memorial Hospital and Research Associate, Sloan-Kettering Institute for Cancer Research.
The Immunologic Aspects of the Allergic Reaction, Daniel J. Stechschulte, M.D., Kansas City, Kan., Chairman, Section of Allergy and Immunology, University of Kansas Medical Center.
Electron Microscopy of Aphthous Stomatitis, Philip Carr Anderson, M.D., Columbia, Chairman and Professor, Dermatology and Allergy, University of Missouri-Columbia School of Medicine.
Rapid Determination of T-Cell Presence in Premature and Newborn Infants, Ronald Moyer, M.D., Kansas City, Fellow, Allergy and Immunology, The Children's Mercy Hospital, University of Missouri-Kansas City School of Medicine.
Sponsored by Missouri State Allergy Association.
[*]11:00 AM *Common Pediatric Gastrointestinal Problems.*
Giulio J. Barbero, M.D., Columbia, Professor and Chairman, Department of Pediatrics, University of Missouri-Columbia School of Medicine and Vice-Chairman, Executive Board of Directors, National Cystic Fibrosis Research Foundation.
Moderator: Robert C. Fairchild, M.D., Kansas City.
Sponsored by Missouri Chapter, American Academy of Pediatrics.
[*]11:00 AM *Gastrointestinal Diseases.*
Moderator: Richard L. Johnson, M.D., Kansas City.
Participants:
The Use of Endoscopy in Upper GI Bleeding, Burnell Landers, M.D., Gastroenterology, Kansas City.
Indications for and Results of Colonoscopy (What Is Colonoscopy?), Walter Harvey Jacobs, M.D., Gastroenterology, Kansas City.
Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).
[*]11:00 AM *Program on Psychiatry.* Sponsored by Missouri Psychiatric Association.
[*]11:00 AM *Biliary Tract Disease.*

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[*] Concurrent Sessions.

Moderator: Russell J. Crider, M.D., St. Charles.
Participants:
Acalculous Gallbladder Disease—The Cholecystokinin Test, Paul F. Nora, M.D., Evanston, Ill., Assistant Professor of Surgery, Northwestern University.
Acalculous Gallbladder Disease in Missouri Hospitals,
Thomas Hendren, M.D., North Kansas City.
William Cole, M.D., Smithton.
John Cottey, M.D., Mexico.
Charles McGinty, Cape Girardeau.
Russell Crider, St. Charles.
Charles Lockhart, Springfield.
Panel Discussion.
Sponsored by Missouri State Surgical Society.

12:30 PM Missouri University Alumni Luncheon.
Missouri Obstetrical-Gynecological Society Luncheon.

* 2:00 PM Presiding: Jean Chapman, M.D., Cape Girardeau, President-Elect, Missouri State Allergy Association.
Participants:
Pulmonary Hypersensitivity Syndrome, Raymond Slavin, M.D., St. Louis, Professor of Internal Medicine and Director, Section of Allergy and Immunology, St. Louis University School of Medicine.
Contemporary Considerations in Clinical Immunology, Norman T. Berlinger, M.D., New York, N. Y., Fellow, Clinical Immunology Service, Memorial Hospital and Research Associate, Sloan-Kettering Institute for Cancer Research.
Disodium Cromoglycate in Pediatric Office Practice, Lester Wall, M.D., St. Louis, Assistant Clinical Professor of Pediatrics, St. Louis University School of Medicine.
Thermography in Clinical Allergic Diseases, Laurie Smith, M.D., St. Louis, Fellow, Section of Allergy and Immunology, St. Louis University School of Medicine.
The Concepts of Allergic Treatment Including Hyposensitization and Regulation of Mediator Release, Daniel J. Stechschulte, M.D., Kansas City, Kan., Chairman, Section of Allergy and Immunology, University of Kansas Medical Center.
Question and Answer period.
Sponsored by Missouri State Allergy Association.

* 2:00 PM *Pre-Hospital Coronary Care*, Richard P. Lewis, M.D., Columbus, Ohio, Chairman, Department of Cardiology, Ohio State University.
Natural History of Coronary Artery Disease, David R. McConahay, M.D., Kansas City, Assistant Clinical Professor of Medicine, University of Missouri-Kansas City.
Moderator: Ben D. McCallister, M.D.
Sponsored by Missouri Heart Association, Inc.

* 2:00 PM *Pulmonary Diseases.*
Moderator: Lees C. Forsythe, M.D., Kansas City.
Participants:
Understanding Blood Gases, George S. Devins, M.D., Pulmonary Diseases, Kansas City.
Management of C.O.P.D., Robert A. Raich, M.D., Internal Medicine, Kansas City.
Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).

* 2:00 PM *Social and Medical Factors of Alcoholism*, Maxwell N. Weisman, M.D., Baltimore, Md.
Moderator: R. Gordon McAfee, M.D., Kansas City.
Sponsored by Missouri Psychiatric Association.

* 2:00 PM *Pulmonary Problems in Surgical Patients.*
Moderator: Andrew McCanse, M.D., Kansas City.
Participants:
Meaning and Interpretation of Blood Gas Measurements, Robert Senior, M.D., St. Louis, Director, Pulmonary Laboratories, The Jewish Hospital of St. Louis.
Ventilatory Problems in Surgical Patients—Recognition and Therapy, John Collins, M.D., St. Louis, Associate Professor of Surgery, Washington University School of Medicine.
Panel Discussion and Questions.
Sponsored by Missouri State Surgical Society.

3:30 PM Intermission to View Exhibits.

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* Concurrent Sessions.

4:00 PM **House of Delegates, second session.**
5:30 PM Missouri State Medical Foundation Annual Meeting.
6:00 PM Reference Committee Meetings.
6:00 PM Dinner Meeting: Missouri State Allergy Association.
6:30 PM Dinner Meeting: Missouri State Surgical Society.
6:30 PM Dinner Meeting: Missouri Psychiatric Association.

Saturday, April 6

8:00 AM Registration.
*9:00 AM *Cardiovascular Diseases I.*
Moderator: M. R. Troeh, M.D., Independence.
Participants:
Bedside Evaluation of Cardiovascular Function, James E. Crockett, M.D., Cardiovascular Diseases, Kansas City.
Heart Sounds, Carlton L. Shmock, M.D., Cardiovascular Diseases, Kansas City.
Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Division).
*9:00 AM Cataract Surgery: Miles Galin, M.D., New York City, Professor and Chief, Department of Ophthalmology, New York Medical College.
Moderator: Felix Sabates, M.D., St. Louis.
Sponsored by Missouri Ophthalmological Society, Inc.
*9:00 AM *Program on Urology.* Sponsored by Federation of Missouri Urologists.
9:00 AM *Trauma and Emergency Care Services.*
Moderators: Marshall T. Metzgar, M.D., Columbia.
Howard Linville, M.D., Kansas City.
Participants:
Emergency Care Systems, Eugene Nagel, M.D., Miami, Fla., Professor of Anesthesiology, University of Miami School of Medicine.
What Is St. Louis Doing?, Allen P. Klippel, M.D., St. Louis.
What Is Kansas City Doing?, Gerald Tuohy, M.D., Kansas City.
What Is Rural Missouri Doing?, Frank Mitchell, M.D., Columbia.
What Should Missouri Be Doing?, Senator William J. Cason, Clinton.
Sponsored by Missouri Society of Anesthesiologists and Missouri State Surgical Society.
9:30 AM **Speak Out to Your AMA Delegates.**
(Missouri's AMA Delegates and Alternates will be available for an open forum type discussion for all MSMA members regarding positions and opinions on AMA-related subjects.)
10:30 AM **Intermission to View Exhibits.**
10:45 AM *Trauma and Emergency Care Services* (Continued).
Participants:
Categorization of Emergency Medical Services, Oscar Hampton, M.D., St. Louis, Professor of Orthopedic Surgery, Washington University School of Medicine.
Panel Discussion—Drs. Nagel, Hampton, Tuohy, Klippel, Mitchell and Senator Cason.
Sponsored by Missouri Society of Anesthesiologists and Missouri State Surgical Society.
*11:00 AM *Cardiovascular Diseases II.*
Moderator: M. R. Troeh, M.D., Independence.
Participants:
Medical Management of Acute Myocardial Infarction, Keith H. Averill, M.D.. Cardiovascular Diseases, Kansas City.
Surgical Management of Acute Myocardial Infarction, William A. Reed, M.D. and Duncan A. Killen, M.D., Cardiovascular Surgery, Kansas City.
Sponsored by Missouri Society of Internal Medicine and American College of Physicians (Missouri Region).
*11:00 AM *Transmission of Disease by Blood Transfusion.*
William L. Bayer, M.D., Kansas City, Medical Director, Community Blood Center of Kansas City.
Moderator: Thomas J. Fritzlen, M.D., Kansas City.
Sponsored by Missouri Society of Pathologists, Inc.
*11:00 AM *Evaluation and Management of Low Back Disorders.*
Rene Cailliet, M.D., Los Angeles, Calif., Chairman and Professor, Department of Rehabilitation Medicine, University of Southern California.
The Multidisciplinary Approach to the Treatment of Arthritis, Charles R. Peterson, M.D., Columbia, Professor and Chairman, Department of Physical Medicine and Rehabilitation, University of Missouri-Columbia School of Medicine.
The Rehabilitation of the Stroke Patient—When, Where and How, Franz U. Stein-

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* Concurrent Sessions.

berg, M.D., St. Louis, Director, Department of Rehabilitation Medicine, The Jewish Hospital of St. Louis.
Moderator: Franz U. Steinberg, M.D., St. Louis.
Sponsored by Physical Medicine and Rehabilitation.
*11:00 AM *Diagnostic Radiology.*
Moderator: Sheldon E. Berenson, M.D., Kansas City.
Participants:
Respiratory Diseases of the Newborn, John C. Leonidas, M.D., Kansas City, Professor of Radiology, University of Missouri-Kansas City.
Cystography in Children, William H. McAlister, M.D., St. Louis, Professor of Radiology and Chief, Section of Pediatric Radiology, Mallinckrodt Institute of Radiology.
Sponsored by Missouri Radiological Society.
12:15 PM Missouri Ophthalmological Society, Inc., Luncheon.
12:30 PM 50-Year Club Luncheon.
Physiatrics Luncheon.
Missouri State Society of Neurological Surgeons Luncheon.
12:45 PM MSMA-MMPAC General Luncheon.
Guest Speaker—William J. Cason, Clinton, President Pro-Tem, Missouri Senate.
*2:30 PM *Tumor Immunology.*
Moderator: Andrew McCanse, M.D., Kansas City.
Participants:
Basic Science Aspects of Clinical Immunology, Paul Morse, Ph.D., The University of Kansas Medical Center, Kansas City, Kan.
Immunology in the Diagnosis of Malignant Disease, George Pierce, M.D., The University of Kansas Medical Center, Kansas City, Kan.
Immunotherapy of Solid Tumors, William R. Jewell, M.D., The University of Kansas Medical Center, Kansas City, Kan.
Sponsored by American Cancer Society, Missouri Division.
*2:30 PM *Program on Dermatology.*
Guest Speaker: Samuel Gluegarb, M.D., Evanston, Ill., Professor of Dermatology, Northwestern University School of Medicine.
Sponsored by Missouri Dermatological Society, Inc.
*2:30 PM *The Family Physician and the Management of ENT Problems.*
Moderator: Lindsay L. Pratt, M.D., St. Louis.
Panel Participants:
Nose Bleeds—Robert Hazen, M.D., Kansas City.
Sinus Disease—Carl Ehrlich, M.D., St. Louis.
Middle Ear Disease—Donald Joseph, M.D., Columbia.
The Dizzy Patient—Malcolm Stroud, M.D., St. Louis.
Maxillofacial Tumors and Injuries—Floyd Barnhill, M.D., Springfield.
Sponsored by Missouri Ear, Nose and Throat Association, Inc.
*2:30 PM *Metabolic Diseases.*
Participants:
Management of Labile Diabetes, Jerome A. Grunt, M.D., Pediatric Endocrinology, Kansas City.
Diagnosis and Treatment of High Blood Lipids, Ralph R. Hall, M.D., Internal Medicine, Kansas City.
Sponsored by Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).
*2:30 PM *Diagnostic Radiology* (Continued)
Moderator: Sheldon E. Berenson, M.D., Kansas City.
Participants:
Clinical Uses of Diagnostic Ultrasound, Jack L. Stuber, M.D., Kansas City, Assistant Professor of Radiology, University of Missouri-Kansas City.
Upper Respiratory Air-way Obstruction in Children, William H. McAlister, M.D., Professor of Radiology and Chief, Section of Pediatric Radiology, Mallinckrodt Institute of Radiology.
Sponsored by Missouri Radiological Society.
4:00 PM Intermission to View Exhibits.
5:00 PM St. Louis University Medical Alumni Cocktail Party.
5:00 PM Washington University Medical Alumni Cocktail Party.
5:00 PM Missouri University Medical Alumni Cocktail Party.
6:30 PM Missouri Dermatological Society, Inc., Cocktails and Dinner.
6:30 PM Social Hour for Those Attending Banquet.
7:15 PM Annual Banquet in Honor of Past-Presidents.

Sunday, April 7

7:30 AM House of Delegates. Breakfast and Final Session.

OFFICIAL DELEGATES

116th MSMA Annual Session

County	*Delegates*	*Alternates*
Andrew	Warren C. Baker, Savannah	J. L. Villahermosa, Savannah
Audrain	Benjamin N. Jolly, Mexico	Edgar S. Wallace, Mexico
Barton	Thomas W. Carroll, Lamar	Herbert M. Arnold, Lamar
Boone	Hugh E. Stephenson, Jr. Columbia	Thomas W. Burns, Columbia
"	William B. See, Columbia	George J. Fuchs, Jr., Columbia
"	John T. Logue, Columbia	Kenneth L. Rall, Columbia
"	Benedict A. Moranville Columbia	William C. Allen, Columbia
"	Kenneth K. Keown, Columbia	Marshall T. Metzgar, Columbia
"	George P. Wilson, Columbia	William L. Donegan, Columbia
Buchanan	Allen I. Herman, St. Joseph	R. Philip Acuff, St. Joseph
"	John T. Rogers, St. Joseph	Gerald E. Fox, St. Joseph
"	Ernest E. Wadlow, St. Joseph	Donald J. Stallard, St. Joseph
"	William B. Rost, St. Joseph	Richard V. Riddell, St. Joseph
Butler-Wayne-Ripley	George H. Ladyman Poplar Bluff	Austin Tinsley, Poplar Bluff
"	T. Eugene Ruff, Poplar Bluff	Bennie N. Till, Poplar Bluff
"	Fred Caldwell, Poplar Bluff	S. K. Reddy, Poplar Bluff
Callaway	Vernon B. Jackson, Fulton	James K. Ritterbusch, Fulton
Cape Girardeau	Edwin K. Burford, Jr. Cape Girardeau	Clifford R. Talbert, Cape Girardeau
"	Harold B. Rapp, Cape Girardeau	Charles H. Cozean, Jr., Cape Girardeau
"	Melvin C. Kasten Cape Girardeau	John K. Holcomb, Cape Girardeau
Chariton-Macon-Monroe-Randolph	D. D. Stuart, Brunswick	F. L. Harms, Salisbury
"	D. E. Eggleston, Macon	J. E. Campbell, Macon
"	F. A. Barnett, Paris	W. D. Chute, Moberly
"	P. V. Dreyer, Huntsville	C. C. Cohrs, Moberly
Clay	Richard P. Bowles, Liberty	Paul Revare, Kansas City
"	Chris K. Fotopoulos North Kansas City	Truman B. Schertz, North Kansas City
"	Donald E. Kuenzi, Kansas City	William R. McPhee, Kansas City
Clinton	Larry A. Ozenberger, Plattsburg	Paul T. Luckenbill, Plattsburg
Cole	Jack S. Sanders, Jefferson City	Robert H. Tanner, Jefferson City
"	Byron E. Watts, Jefferson City	Henry V. Guhleman, Jr., Jefferson City
"	Thomas J. Ryan, Jefferson City	G. Donald Shull, Jefferson City
Cooper	George W. Winn, Boonville	
Dallas-Hickory-Polk-Dade	O. A. Griffin, Buffalo	
"	George G. Robinson Humansville	
"	Evelyn Griffin, Buffalo	
"	Lee A. McNeel, Jr., Greenfield	
Dunklin	George Q. Dunmire, Kennett	John K. Legan, Kennett
Franklin-Gasconade-Warren	William R. Richardson, Union	James G. Shea, Washington
"	George Workman, Hermann	Thomas J. Mitchell, St. Clair
"	Harold Hoelscher, Warrenton	Charles H. Sincox, Washington

County	*Delegates*	*Alternates*
Grand River		
Caldwell	Frank R. Daley, Hamilton	
Carroll	John H. Platz, Carrollton	E. Warren Allen, Carrollton
Daviess	J. Larry Dowell, Pattonsburg	
DeKalb	Fred K. Wilson, Winston	
Grundy	Albert D. Cross, Trenton	David L. Ryan, Trenton
Harrison	Watkins A. Broyles, Bethany	Merriam Gearhart, Bethany
Linn	John R. Dixon, Brookfield	Theodore George, Marceline
Livingston	George Mandler, Chillicothe	Joseph A. Conrad, Chillicothe
Mercer		
Greene	Stanley S. Peterson, Springfield	Henry B. Ivy, Springfield
"	Walter A. German, Springfield	Ramon Shane, Springfield
"	William M. Walker, Springfield	Donald H. Beisner, Springfield
"	Bruce I. Shackter, Springfield	Ernest Lorenc, Springfield
"	Thomas P. Sweeney, Springfield	David L. Spalding, Springfield
"	James T. Brown, Springfield	Richard Loeb, Springfield
"	Noel R. Lewis, Springfield	Leo M. Wyrsch, Springfield
Henry	Richard H. King, Clinton	R. S. Hollingsworth, Clinton
Howard	William G. Marshall, Glasgow	Francis D. Dean, Fayette
Jackson	Fred D. Fowler, Kansas City	R. Glenn Elliott, Kansas City
"	Warren F. Wilhelm, Kansas City	Harry S. Jonas Independence
"	C. Y. Thomas, Jr., Kansas City	Jacob Kraft, Kansas City
"	T. J. Bryant, Kansas City	Burnell Landers, Kansas City
"	Edwin E. MacGee, Kansas City	Robert A. Raich, Kansas City
"	Pat A. Barelli, Kansas City	Lafe W. Bauer, Kansas City
"	Martin L. Crow, Kansas City	James W. Neumann, Kansas City
"	Robert C. Fairchild Shawnee Mission, Kans.	Ronald A. Youmans, Kansas City
"	Robert W. Forsythe Kansas City	George P. Williams, Kansas City
"	John A. Griffith, Jr. Kansas City	Thomas J. Fritzlen, Kansas City
"	Edward E. Haith, Kansas City	Vance E. Link, Independence
"	William D. Hoadley Kansas City	Robert W. Doering, Kansas City
"	Walter H. Jacobs, Kansas City	John A. Sheahon, Kansas City
"	George J. Lytton, Kansas City	Earl G. Padfield, Jr., Kansas City
"	Andrew McCanse, Kansas City	Herbert J. Waxman, Kansas City
"	Richardson K. Noback Kansas City	Daniel J. Cutcliff, Kansas City
"	Milton B. Ozar, Kansas City	Sidney F. Pakula, Kansas City
"	Gordon A. Sauer, Kansas City	
"	Robert A. Slickman, Kansas City	
"	O. Dale Smith Prairie Village, Kansas	
"	W. Jack Stelmach, Kansas City	
"	Alfred D. Biggs, Jr., Kansas City	
"	Calvin E. Engelmann Kansas City	
"	Braham J. Geha, Kansas City	
"	R. Stacy Long, Kansas City	
"	Mark D. Ost, Kansas City	
"	John M. Singleton, III Kansas City	
Jasper	John R. Esther, Joplin	Andrew J. Fritsch, Joplin
"	Marvin A. Singleton, Joplin	Charles S. Davis, Joplin
"	F. Wendell Pence, Carthage	Frank H. Birsner, Carthage
Jefferson	Vicente D. Deles, Crystal City	J. Logan Mayfield, Crystal City
Johnson		

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Lafayette-Ray	William C. LaHue, Lexington	Robert R. Pavlu, Waverly
"	Thomas Riley, Richmond	George K. Davault, Richmond
Lewis-Clark-Scotland	Landis Y. Davis, Canton	
Marion-Ralls-Shelby	Thomas J. Fischer, Hannibal	Edward M. Plowman, Hannibal
"	Phillip B. Foreman, Hannibal	Carl R. Kruse, Palmyra
"	James K. Mann, Hannibal	Stanley Hall, Hannibal
Mid-Missouri		
Crawford	Frank A. Elders, Cuba	
Dent	B. J. Bass, Salem	
Laclede	Rae W. Froelich, Lebanon	Roy E. Mitchell, Salem
Maries	Earl E. Feind, Rolla	
Phelps	Barbara E. Russell, Rolla	
Pulaski	Clyde S. Miller, Waynesville	Dennis E. Hite, Lebanon
Miller	Carl T. Buehler, Jr., Eldon	Edward O. Shelton, Eldon
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Iron	Robert Dettmer, Ironton	Marvin Menne, Ironton
Madison	A. R. Rao, Fredericktown	Metin Arat, Farmington
Washington	Carlos Borromeo, Flat River	Paul Dennis, Desloge
Reynolds	A. G. Karraker, Farmington	C. H. Appleberry, Rivermines
Bollinger	Norma Farmer, Farmington	Jack Mullen, Bonne Terre
Moniteau	Richard B. Fulks, California	L. M. Gallagher, California
Montgomery	Samuel J. Byland, Wellsville	
Morgan	C. Robert Hall, Versailles	J. Loren Washburn, Versailles
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Adair	Milton T. English, Kirksville	E. M. Grim, Columbia
Knox	Francis Tarvydas, Edina	
Schuyler		
Sullivan		
Putnam		
Northwest		
Nodaway	Robert E. Dunshee, Maryville	
Holt	James Humphrey, Mound City	E. D. Imes, Maryville
Atchison	Edward F. Bare, Tarkio	John M. Wanamaker, Rock Port
Gentry	Troy O. Morgan, Jr., Albany	Albert L. Carlin, Stanberry
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Stone	Fred Wommack, Crane	
Barry	Sergio G. Cruz, Jr., Monett	Andres G. Apostol, Monett
Newton	Paul B. Anderson, Neosho	Roy E. Kenney, Neosho
Christian	Stanley D. Roper, Ozark	
McDonald	George W. Blankenship, Neosho	
Taney	Roy Gillispie, Branson	James W. Crain, Branson
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"	Martin L. Key, Ste. Genevieve	Joseph F. Lutkewitte, Ste. Genevieve
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Pike	Charles H. Lewellen, Louisiana	Glenn E. Miles, Louisiana
Platte		
St. Charles-Lincoln	Paul H. Rother, St. Charles	James P. Felder, St. Charles
"	John C. Soucy, St. Charles	Gary Vart, St. Charles
"	Edward Damron, Elsberry	Joseph Creech, Troy
St. Louis City	Walter F. Ballinger, St. Louis	P. Alonso-Yague, St. Louis
"	Richard V. Bradley, St. Louis	John P. Arnot, St. Louis
"	George Brennan, St. Louis	Arthur Baue, St. Louis
"	Pablo C. DeUngria, St. Louis	Ralph Biddy, St. Louis
"	Richard H. Fallon, St. Louis	Mary Bishop, St. Louis
"	Robert H. Felix, St. Louis	Helen Bruce, St. Louis
"	Thomas Ferguson, St. Louis	Robert Drews, St. Louis

County	*Delegates*	*Alternates*
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"	George Hawkins, St. Louis	Richard Ferry, St. Louis
"	James Haynes, St. Louis	Murray Finn, St. Louis
"	Ronald Hoffman, St. Louis	Raymond Frederick, St. Louis
"	Patrick C. Hogan, St. Louis	Donald Goodwin, St. Louis
"	Charles A. Jost, St. Louis	Lee B. Heutel, St. Louis
"	Robert W. Kelley, St. Louis	James Hickey, St. Louis
"	Charles Kromer, St. Louis	John Kellett, St. Louis
"	Lawrence Lawton, St. Louis	John J. Kelly, St. Louis
"	Paul F. Max, St. Louis	Richard Kloecker, St. Louis
"	R. Bruce McCloskey, St. Louis	Robert Kuhlman, St. Louis
"	F. Eugene Pennington, St. Louis	William MacDonald, St. Louis
"	Herman Russell, St. Louis	Daniel Martin, St. Louis
"	Percival Salanga, St. Louis	Roger Mell, St. Louis
"	Joseph B. Vacca, St. Louis	Vernon Michael, St. Louis
"	Carol F. Williams, St. Louis	William Mill, Jr., St. Louis
"	Luis B. Anglo, St. Louis	Robert Miller, St. Louis
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"	George Bohigian, St. Louis	Daniel O'Sullivan, St. Louis
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"	Thomas J. Cooper, St. Louis	Gordon Philpott, St. Louis
"	Daniel M. Fraser, St. Louis	George Rendelman, Jr., St. Louis
"	August W. Geise, St. Louis	Jose Reyes, St. Louis
"	Charles R. Gulick, St. Louis	John Sciortino, St. Louis
St. Louis City	James N. Heins, St. Louis	Edward Wirthlin, St. Louis
"	Donald R. Judd, St. Louis	Edward Wittgen, St. Louis
"	Francis X. Lieb, St. Louis	R. Dean Wochner, St. Louis
"	J. Otto Lottes, St. Louis	Horst Zekert, St. Louis
"	Philip Luedde, St. Louis	Jerome T. Y. Shen, St. Louis
"	R. Reilly Maginn, St. Louis	Andrew Signorelli, St. Louis
"	Michael G. Murphy, St. Louis	William Smiley, St. Louis
"	Frank J. Niesen, St. Louis	Donald Spalding, St. Louis
"	Lawrence W. O'Neal, St. Louis	Paul Stohr, St. Louis
"	Theodore L. Paletta, St. Louis	Robert Tatkow, St. Louis
"	Harry A. Reich, St. Louis	Oliver Tjoflat, St. Louis
"	Hubert A. Ritter, St. Louis	Clarence Turner, St. Louis
"	Charles S. Sherwin, St. Louis	James Utley, St. Louis
"	James M. Stokes, St. Louis	Leo Wacker, St. Louis
"	George Zografakis, St. Louis	J. Leslie Walker, St. Louis Roger Vardeleon, St. Louis
St. Louis County	Vernon H. Balster, St. Louis	Morris D. Marcus, St. Louis
"	C. Read Boles, St. Louis	Herluf G. Lund, St. Louis
"	Rudolph E. Catanzaro, St. Louis	Robert H. Lund, St. Louis
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Wright	James A. Hasek Mountain Grove	O. Martin Hasek Mountain Grove

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Howell	W. Thomas Morgan, Jr. West Plains	Marvin L. Fowler, West Plains
Oregon	A. T. Walker Mammoth Springs, Ark.	Jack Langevin, West Plains
Douglas	C. Franklin Smith Willow Springs	Rollin H. Smith, West Plains
Ozark	Jack N. Wiles, West Plains	
Webster	T. M. Macdonnell, Marshfield	R. J. Bareis, Marshfield
West Central		
Bates	Arthur L. Hansen, Butler	William W. Haynie, Butler
Cass	Alfred W. Eklund, Pleasant Hill	Robert O. Wheeler, Harrisonville
Cedar	Harry V. Langeluttig, Jr. El Dorado Springs	Robert L. Magee, El Dorado Springs
St. Clair	Glen H. Reed, Appleton City	Donald H. Giesler, Osceola
Vernon	R. John Torontow, Nevada	C. Braxton Davis, Nevada

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Ralph Perry, Kansas City
H. E. Petersen, St. Joseph
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12	Armour Pharmaceutical Company Phoenix, Arizona
4	Astra Pharmaceutical Products, Inc. Worcester, Massachusetts
14	Blue Cross—Blue Shield Kansas City, Missouri
20	Boehringer Ingelheim Ltd. Elmsford, New York
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22	Data Service Agency, Inc. Maryland Heights, Missouri
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11	Southern Medical Association Birmingham, Alabama
6	Tab Products Company St. Louis, Missouri
29	United Medical Equipment Co. Kansas City, Missouri
23	United States Air Force Medical Services Washington, D.C.
16	The Upjohn Company Kalamazoo, Michigan

In lieu of exhibits, the following firms made cash donations to assist in the sponsorship of Scientific Sessions:

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WASHINGTON

President Nixon is enthusiastically endorsing the Health Maintenance Organizations program effort getting underway at the HEW Department, according to federal health officials.

The government is "going all out" to implement the new law "as rapidly as possible," Charles Edwards, M.D., Assistant HEW Secretary for Health, said.

Proposed regulations to carry out the HMO program will be issued by the end of March.

At a briefing of health reporters, Dr. Edwards announced that the director of the HMO program is Frank Seubold who has been serving as Deputy Director of the old HMO office as well as Associate Director of the Bureau of Community Health. Seubold, 51, is a Ph.D. chemist who came to HEW in 1971 after a career in the aerospace industry in California during which he became increasingly involved in space medicine and medical systems management work.

With respect to the new HMO law that authorizes $375 million over the next five years, Dr. Edwards said that, for the first time, the government is going to be making changes in the economic base of health care delivery in this country. The HMO concept attains added importance, he told reporters, as the Administration and Congress move on national health insurance proposals.

* * *

Health outlays last fiscal year for the nation reached $94.1 billion, an 11% increase, the lowest rate in several years. The proportion of total health spending to the Gross National Product remained at the 1972 level—7.7%. Per capita expenditures rose $41 to $441, including private and government spending.

The Social Security Administration's preliminary figures for the fiscal year that ended last July showed per capita private spending on health of $265 and government spending of $176 per person for the year.

The ratio of public-versus-private health spending continued the trend of two decades toward more government spending. The ratio for fiscal 1973 was 60.1% private and 39.9% public. In 1928, the corresponding ratio was 86.7% and 13.3%.

Of the $94 billion total, $36 billion went for hospital care, $18 billion for physicians' services, compared with $32.6 billion and $16.6 billion the previous year.

Federal spending was estimated at $24.6 billion, up almost $2 billion; state and local, $12.9 billion, up more than $1.5 billion.

Expenses for prepayment and administration, largely private health insurance expenses, rose from $2.4 billion in fiscal 1972 to $3.3 billion in fiscal 1973.

* * *

Dr. John Zapp, D.D.S., Deputy Assistant Secretary for Legislation of the HEW Department, is resigning to join the Washington office of the AMA as Director of the Department of Congressional Relations.

Dr. Zapp has been at HEW since 1969. He held a variety of posts including Deputy Assistant Secretary for Health Manpower. The 41-year-old official has been involved with health legislation for several years and has served as federal representative to the AMA-American Medical Colleges Liaison Committee on Medical Education. He will replace William Colley as the head of AMA's Congressional Relations Department.

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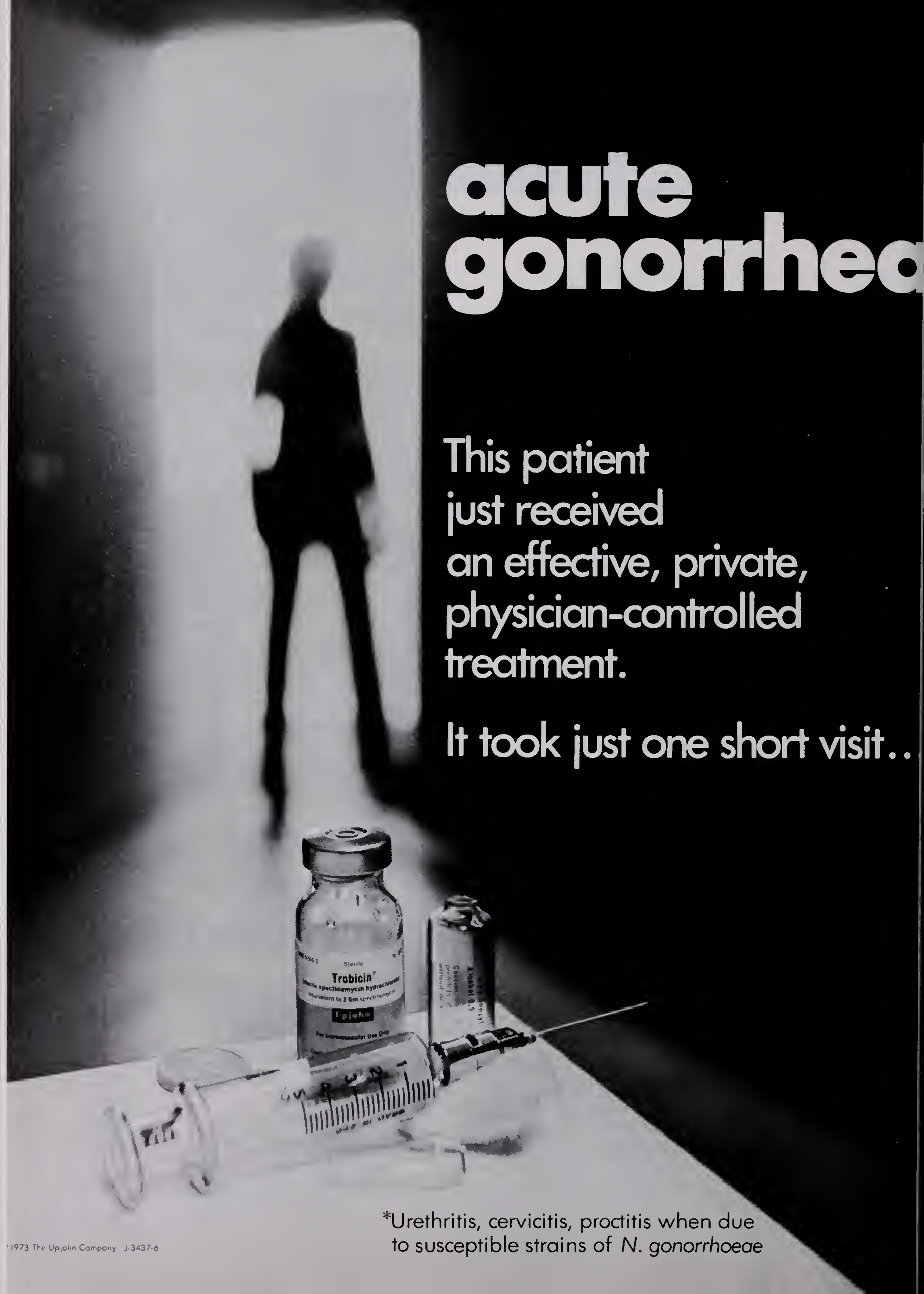
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Trobicin®
spectinomycin hydrochloride
equivalent to 2 Gm spectinomycin
Upjohn
For Intramuscular Use Only

acute gonorrhe

This patient
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It took just one short visit..

*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and **Trobicin**® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae.*

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae.*

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—**Inject 5 ml intramuscularly** for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—**Inject 10 ml intramuscularly** for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae.*
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

The Council Reports

Meeting of December 15, 1973

R. Allen Chandler, M.D., Kansas City, Chairman, called the meeting to order. Those present were Drs. Chandler; E. A. Stricker, St. James; James C. Cope, Columbia; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; Walter T. Gunn, St. Louis; Lysle Bach, Hannibal; Max S. Franklin, St. Louis; Louis P. Hetlage, Troy; Robert Bregant, Jefferson City; William D. Bradshaw, Clinton; Claude Cooper, Thayer; E. T. Hansbrough, Poplar Bluff; R. A. Slickman, Kansas City; Stanley S. Peterson, Springfield; J. Loren Washburn, Versailles; Joseph White, William D. Mayer, William C. Allen, and Paul R. Young, Columbia; R. K. Noback, Kansas City; Messrs. Hollister S. Smith, St. Louis; Ray McIntyre, Tom P. Fox, Royal O. Cooper and C. C. Swarens, Staff.

Dr. Chandler called the meeting to order and requested approval of the minutes of the Sept. 29-30, 1973 Council meeting. On motion, duly seconded, the Council minutes of Sept. 29-30 were approved as printed in the December, 1973 issue of Missouri Medicine.

REPORT OF THE EXECUTIVE SECRETARY

Mr. McIntyre indicated that Mr. Noble could not be present for the Council meeting. The briefs on both sides have been filed in the HCF suit with the St. Louis Court of Appeals. In early January, the Court will assign this case to a judge of the Court who will research the case and make recommendations to the Court. Following that, the Court will make its final decision.

A letter was received from the College of American Pathologists regarding their program for promoting quality laboratory services in private physicians' laboratories. This entails surveying or determining by a certain procedure of questionnaires sent out and certain standards set up to determine whether the private physicians' laboratories are of the quality they should be. This program was explained to the Council sometime ago by Dr. Blaine Hibbard. The College of American Pathologists wishes to encourage the State Medical Association to establish a Laboratory Quality Committee and to recommend the program they call PEP to its membership.

On motion, duly seconded, it was agreed that this matter be given to the appropriate Commission at the discretion of the Chairman of the Council for report back to the Council.

Mr. McIntyre then referred to a request Dr. Hetlage had made regarding contacting the Osteopathic Association to get their policy on D.O.s attending medical meetings. The Osteopathic Association was contacted and the reply has been turned over to Dr. Hetlage.

REPORT OF THE TREASURER

Dr. Judd presented the Treasurer's report. He reviewed the figures shown in the Treasurer's account minus the accounts payable, which left a balance on hand of $71,676.06 as of Dec. 1, 1973. This does not include the investment account (at cost) of $81,354.07.

On motion, duly seconded, the Treasurer's report was approved.

BUDGET COMMITTEE REPORT

The Budget Committee met on Friday afternoon, Dec. 14, 1973 prior to the Council meeting on Saturday. The Committee reviewed the material presented which showed Exhibit A—Actual Income through Oct. 31, 1973; Expected Total Income for 1973; Income Budget for 1973 and Estimated Receipts for 1974; Exhibit B—Actual Expenditures through Oct. 31; Estimated Expenditures for 1973; Budget for 1973 and Proposed Budget for 1974; Exhibit C—Actual Meeting and Committee Expenses through Oct. 31, 1973; Estimated Expenses for all of 1973; Budget for 1973, and Proposed Budget for 1974. A breakdown of anticipated income and expenses for the years 1973 and 1974 also was included.

Dr. Judd indicated that at the last meeting of the House of Delegates, it was proposed that some money be spent on the educational aspects of MMPAC. This might include preparation of brochures, mailings, postage and part or full time use of a secretary. The Committee suggested the figure of $3,000 for this purpose. Dr. Judd indicated that he would like to point out to the House there has been a response to their request.

Dr. Judd further reported that the Committee recommends setting aside money for the Council to use during the year for certain things that are important for the Council, such as bringing in a particular speaker, etc. This money would be set aside to be used on request of the President or Chairman of the Council and such use would be reported back to the Council at the next meeting. The figure of $5,000 was recommended for this purpose.

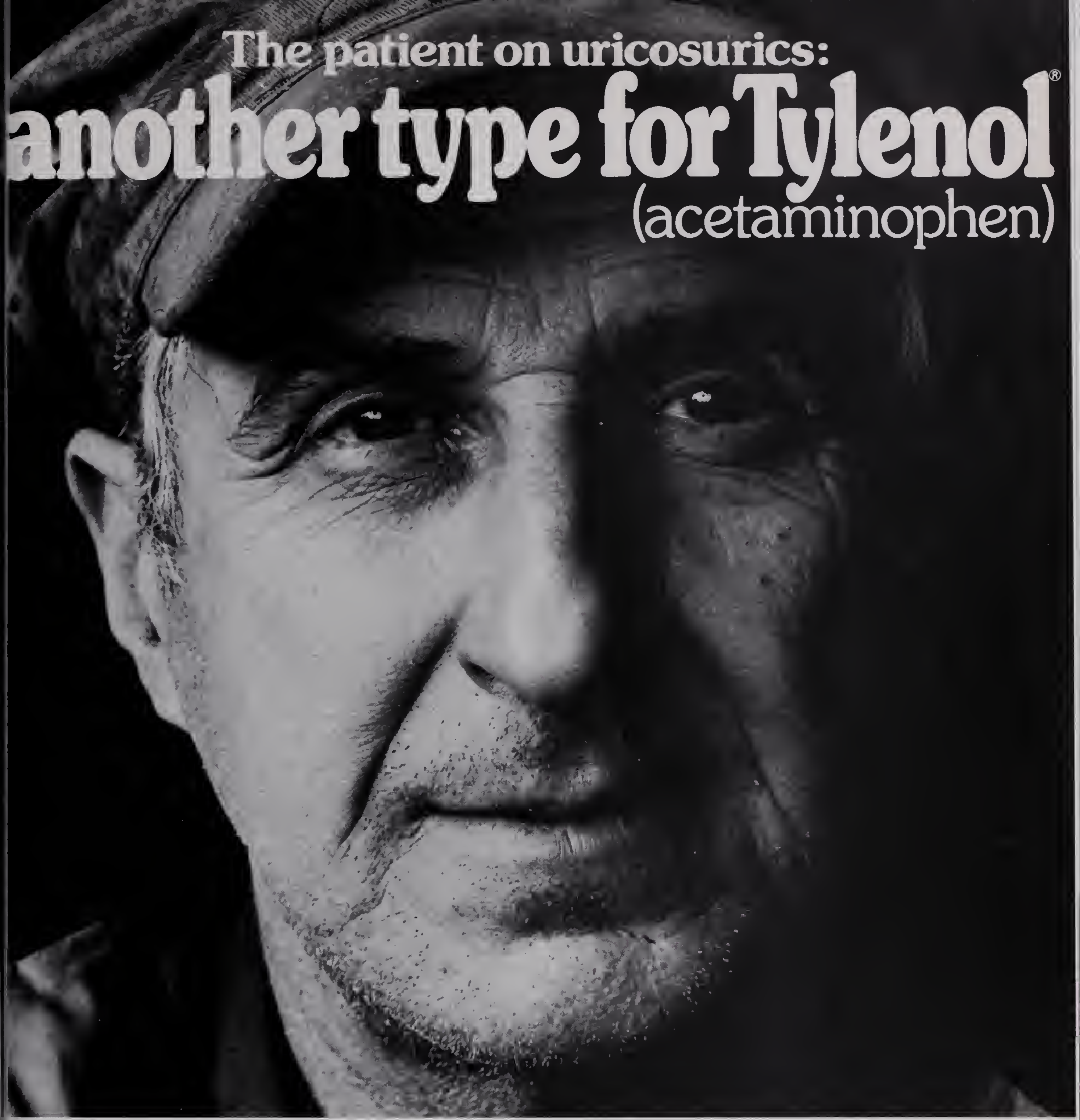
Including the $3,000 and $5,000 items mentioned above, this would give a total budget for 1974 of $367,523. As compared to the estimated receipts for 1974 of $355,675, this would be a deficit of $11,848.

Dr. Judd then requested permission of the Council to contact the Missouri State Medical Foundation (student loan program) and request some financial support from the Foundation. He stated that in the past, the MSMA has supported the Foundation with an assessment. We have provided them with the part-time services of Mr. Fox and a secretary. Dr. Judd proposed that a reasonable and conservative estimate would be that about 30% of their total salaries might be recovered from the Foundation. This would give MSMA an additional $6,600. Subtracted from the $11,848, that would leave a total deficit of $5,248.

The Budget Committee approved the following proposed budget for 1974:

Salaries	$136,198
Furniture and Fixtures	750
General Expense	3,700
Office Supplies	5,000
MSMF Assessment	39,870
Journal Expense	40,000
Postage	6,000
Equipment Rentals and Repairs	4,000
Telephone and Telegraph	8,000
Pension Expense (Insurance and Retirement)	21,500
Legal and Professional	10,000
Payroll Taxes	6,250
Commission-Committee Meetings	35,600
Annual Session	22,000
Taxes—I.R.S.	1,800
Travel Expenses	6,000

(Continued on page 142)



When the patient on uricosuric therapy requires an analgesic, a new problem arises. Aspirin in the usual analgesic doses inhibits the action of uricosurics.[1,2]

TYLENOL (acetaminophen), on the other hand, causes no appreciable uricosuric antagonism[2] and for this reason is preferred over aspirin in the gout patient.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin,
yet just as effective for relief
of pain and fever

Tylenol®
(acetaminophen)

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These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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GENE B. STARKLOFF, M.D., BRUCE M. WOLFE, M.D. *and*
KENNETH R. RAMACH, M.D., *St. Louis*

Management of Complications Following Intestinal Bypass for Morbid Obesity

Surgical procedures designed to aid the morbidly obese produce a controlled state of reduced absorption that ideally should be compatible with good health and produce a sustained reduction of weight to normal or near normal levels. Some patients treated by jejunal-ileal bypass will develop complications related to absorption. The management of these complications forms the basis of this report.

Since the original operation in 1970, we have operated on 350 morbidly obese patients. All patients had jejunal-ileal bypass, either end-to-end or end-to-side. All patients were of double or greater than double normal weights and all had been obese seven years or more. Most patients had been obese since childhood. The age range was 16 to 62. Complications in order of frequency were as follows:

Diarrhea

Ninety per cent of patients developed diarrhea. The diarrhea was of varying degrees of severity. Most diarrhea is precipitated by the ingestion of fats. This is particularly true early in the postoperative period. Most of the patients are able to eat a general diet without fat restriction by the time a year to 18 months has passed. When diarrhea is severe and consists of more than six to ten stools per 24 hours, it is controlled by the use of 2.5 mg of diphenoxylate hydrochloride, two tablets four times a day after meals and at bedtime. An occasional patient will respond to the administration of 15 mg of Probanthine three times daily, but we have abandoned the use of Probanthine due to the side effect of dry mouth, producing increased thirst and increased ingestion of fluids. Since these patients have a rapid gastrointestinal transit time, overindulgence in fluids is one of the important causes of diarrhea. When diarrhea occurs, it is recommended that fluid restriction to 1,200 cc-1,500 cc per 24 hours be carried out. Appreciation of the importance of fluid restriction and the recommendation that patients take fluids mainly between meals are frequently overlooked by the physician not accustomed to the management of the patient who has had a (small bowel) bypass operation. Frequently, a patient with a mild urinary tract infection is urged to force fluids which results in severe diarrhea and the production of electrolyte imbalances. Other adjuvant measures in the control

Three hundred and fifty morbidly obese patients have been treated by jejunal-ileal anastomosis since the original operation in 1970. The authors provide this analysis of the complications encountered with suggestions for therapy when these complications occur. Dr. Starkloff is Clinical Professor of Surgery, St. Louis University School of Medicine. Dr. Wolfe is Chief Resident and Dr. Ramach is Resident, St. Louis University Hospitals.

of diarrhea include the administration of 30 mg codeine sulfate every four hours. Occasionally, patients with severe diarrhea obtain most relief by the administration of powdered opium (60 mg, lactose, 240 mg), given every four hours.

Hypokalemia

The most frequent electrolyte imbalance that has been encountered by this group of patients has been hypokalemia. This is usually secondary to uncontrolled diarrhea. Hypokalemia results in muscle weakness and we are especially alert to complaints of generalized muscular weakness in the patient who has had a (small bowel) bypass operation. All patients have potassium determinations every two months during the first postoperative year, every three months during the second postoperative year and more often if symptoms exist or hypokalemia has occurred. We consider serum potassium levels below 3.5 mEq to be an indication for the oral administration of potassium. This is usually done on an outpatient basis, administering 15 cc of potassium chloride 20%, three times daily, and supplying the patient with 60 mEq to 80 mEq of oral potassium per 24 hours. Patients may refuse to take potassium chloride, and K-Lyte and Kalyum are frequently more acceptable substitutes. If the severity of the patient's symptoms indicate markedly depleted potassium levels, if serum potassium levels are 3 mEq or below or if electrocardiographic changes of hypokalemia are present, we consider this an indication for hospitalization and administration of potassium by the intravenous, as well as by the oral route. This intravenous administration of potassium and fluids also is of value in reducing the diarrhea which so often is the etiologic factor in hypokalemia. While some degree of potassium deficit occurs in approximately one third of patients, it should be stressed that severe degrees may be anticipated in uncooperative patients who do not follow dietary restrictions and develop uncontrolled diarrhea. We have had one such patient who subsequently died in the hospital; the cause was a cardiac dysfunction which apparently was secondary to hypokalemia.

Hypocalcemia

Low calcium levels are infrequently encountered. When they occur, they produce troublesome symptoms, including carpopedal spasm, tetany and severe muscular cramps. Early correction of hypocalcemia is important. Hypocalcemia is frequently associated with low serum magnesium values and it is important to determine the level of serum magnesium in all patients who show hypocalcemia. Restoration of calcium deficits is accomplished by the administration of 5 ml of calcium gluconate administered intravenously, once or twice daily, and the oral administration of calcium carbonate. Calcium carbonate is a serendipitous drug in that it modifies bile salt content and may have an ameliorating effect on existing diarrhea. Calcium carbonate is ionized in the stomach and is preferable to calcium gluconate; it should be administered in doses of 2 gm or more three times daily between meals. Our patients have found that aromatic calcium carbonate tablets (Lilly) are most acceptable. When severe depletion of calcium values occurs and during the period of restoration by intravenous and oral administration, we feel that it is valuable to add 50,000 units of Vitamin D twice weekly until calcium values are restored to normal. Magnesium deficits frequently coexist with calcium depletion. Magnesium deficits should be treated when serum magnesium is 1 mEq or lower. Restoration of magnesium has been accomplished by the intramuscular administration of 2 cc of 50% magnesium sulfate once or twice daily, and by the oral administration of magnesium which we have supplied as Mg-PLUS. Prothombin deficits are encountered in a small percentage of patients and usually indicate alteration of intestinal flora and diminished absorption of Vitamin K. Prothrombin deficits, when below 50%, usually can be restored by the administration of intramuscular phytonadine (AquaMephyton). Restoration to normal values is usually rapid. Failure of prothrombin time to return to normal should lead to more careful survey of hepatic function as low prothrombin level may indicate impaired liver function.

Vitamin Deficiencies

The oral administration of therapeutic doses of vitamins is begun postoperatively and should continue indefinitely. Recently, we also have begun the administration of Vitamin B-12, starting at the end of the second postoperative month and continuing once monthly. Schilling tests are obtained every three months and Vitamin A and D levels every six months. If deficiencies exist, Vitamins A and D are administered.

Anemia

Occasionally, patients will show evidence of mild iron deficiency anemia. Most iron deficiency anemias have been found to respond to oral administration of iron, usually in the form of ferrous sulfate (Feosol), 200 mg three times daily. If response has not been adequate to oral iron, iron dextran injection (Imferon) has been administered intravenously, the dosage being determined not according to the description accompanying the Imferon, but on a calculation of body weight combined with the expected red cell mass. A small number of patients have exhibited low serum folates without evidence of megaloblastic anemia. These patients have responded to oral folic acid administration in the increments of 1 mg three times daily.

Gout

While hyperuricemia is frequent in the morbidly obese patient, clinical gout has not been a major problem. When it has occurred, it has responded to the oral administration of the usual medication used in the control of gout in the non-obese patient. Oral administration of colchicine, probenecid and colchicine (ColBenemid), and allopurinol has not produced any marked augmentation of diarrhea. This is in contrast to oral antibiotics which frequently have been the agent that has precipitated most troublesome episodes of diarrhea.

Hepatic Failure

Most patients who are morbidly obese have at the time of operation some degree of fatty infiltration of the liver, which varies from mild to severe. Only 10% of the patients in our series showed no evidence of fatty alteration of the liver. Our studies ndicate that fatty infiltration increases during the first seven to 12 months postoperatively, reaching ts peak usually between the eighth and 11th months. Thereafter, the fatty infiltration begins to subside until at two years the liver frequently has returned to normal morphology. During this early period of augmentation of fatty metamorphosis, the mportance of adequate food intake cannot be overemphasized. We have lost two patients due to advanced fatty necrosis of the liver. Both of these patients were lost to follow-up during the crucial period of fatty metamorphosis. It was determined hat their oral intake had been markedly decreased. It is urged that all patients be instructed on the mportance of maintaining an adequate oral intake. Should this not occur or should liver function tests ndicate deterioration of hepatic function, the patients should be returned to the hospital for upervised oral intake with accurate calorie counts, he administration of medium chain triglycerides and intravenous amino acids and consideration of intravenous hyperalimentation. We have had two patients who showed signs of impending hepatic failure who were aggressively treated, with restoration of liver functions to normal.

Renal Stones

It has been observed that there is an increased propensity for the production of renal stones in the patient who has had a (small bowel) bypass operation. Our studies indicate that this is correlated with increased production of urinary oxalates in the postoperative period. Studies are underway at the present time to confirm this finding and to institute treatment for the high oxalate values. The administration of cholestyramine seemed to be of value in the patients with elevated urinary oxalates. Further reports will be forthcoming on this study.

Cholecystitis and Cholecystolithiasis

The patient who has had a (small bowel) bypass operation has a greater propensity for the development of gall bladder calculi than the normal population of the same age group. Awareness of the potential for this complication is important and periodic study of gall bladder function is of value.

Ventral Hernia

We have used midline upper abdominal incisions in the majority of patients. We have favored this incision because it has allowed us to do the bypass with the greatest ease and to expose the gall bladder and porta hepatis, since many patients require cholecystectomy. Ventral hernia has occurred in 20 patients. Repair has been delayed until patients have returned to near normal weights. At the time of ventral hernia repair, liver biopsy should be done and the length and diameter of the bypass and functioning absorptive bowel should be measured.

Redundant Skin

Unsightly and troublesome redundant skin folds, particularly abdominal folds, have occasionally occurred and have necessitated operation by the plastic surgical service. Operation for removal of abdominal and upper arm skin redundancy usually can be delayed until patients return to near normal weights. The patients over 40 years of age have the greatest problem with redundant abdominal and upper arm skin.

Hair Loss

Ten per cent of patients complained of hair loss

(Continued on page 124)

EDGAR L. LICHTI, Ph.D. *and*
HUGH E. STEPHENSON, M.D., ***Columbia***

Thoracic Outlet Compression Syndrome

The Doppler Ultrasonic Flowmeter as an Aid in Diagnosis and Correction

THE DOPPLER ULTRASONIC FLOWMETER is rapidly becoming a valuable assist to the physician in the diagnostic evaluation, intraoperative management and postoperative follow-up of a large number of vascular lesions. The purpose of this article is to call attention to yet another worthwhile application of the Doppler ultrasonic flowmeter, namely, its use in the evaluation of the patient with a suspected thoracic outlet compression syndrome. Should conservative management be employed through the use of physiotherapeutic measures, such as active neck exercises, heat massage, postural exercises and scalenus antieus muscle stretching, the Doppler provides a quantitative means of evaluating the patient's subjective improvement. Should an operative approach be required to relieve the neurovascular compression, the Doppler ultrasonic flowmeter, using a gas sterilized probe, can be employed throughout the operation to guide the surgeon toward a complete relief of the offending compression factors.

METHOD

Oschner, Gage and DeBakey[1] have pointed out that the scalenus anticus muscle without a cervical rib can be responsible for pressure on the neurovascular bundle causing the symptomology associated with the thoracic outlet syndrome. To ascertain that there is occlusion of the vasculature to the arm, a Doppler probe is placed over the radial artery of the affected arm. The arm is elevated and the probe is maintained in position over the radial artery by fixation with tape (flat probe) or manually. The Adson maneuver is performed and the observer may hear a subjective/objective change in the radial pulse. Any decrease in the volume of the pulse is suggestive that the symptomology may be caused by abnormal pressure at the interscalene triangle. The Doppler probe may be used to follow the subclavian artery. At the point where the abnormality may be found, a "water-hammer" will be heard.

Fig. 1 shows a relatively normal arteriogram of a subclavian artery in a young woman who complained of numbness and pain in her arm. Examination of the extremity with the ultrasonic flowmeter demonstrated normal arterial flow when the arm went through a range of motion to a point 90° to the body. Fig. 1 is arteriographic confirmation of the Doppler findings. At a point approaching 120 to 140 degrees, entrapment of the subclavian artery was complete and arterial flow to the arm was

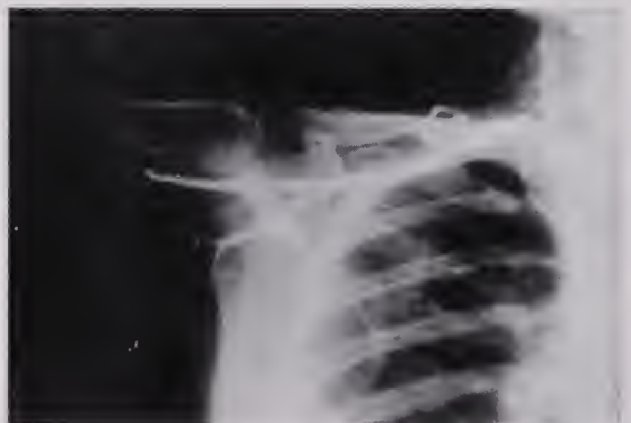

Fig. 1 Right subclavian artery demonstrated angiographically with the arm at 90 degrees to the body.

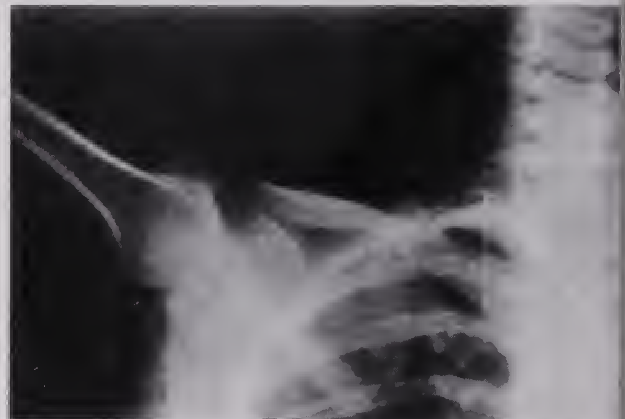

Fig. 2 Occlusion of the subclavian artery by interscalene triangle when the arm is hyper-abducted and an Adson maneuver is performed.

diminished and, in this case, completely blocked. Arteriographic confirmation was made of the Doppler findings and is shown in Fig. 2. An Adson maneuver diminished the pulsatile flow when examined by ultrasonic flowmeter, though no noticeable change was felt with manual palpation.

Confirmation of ultrasonic findings by arteriography followed by subsequent surgical exploration revealed interscalene muscle entrapment of the subclavian artery. The scalenus anticus was divided and the entrapped neurovascular bundle was freed. A segment of the muscle band was removed to prevent further entrapment. A sterile Doppler probe was used on the radial artery of the hand while the arm was put through a complete range of motion on the operating table. No diminishment of the pulse was noted. The subclavian artery was examined with the sterile probe, and no "water-hammer" was heard. The patient had full relief of symptomology and has experienced no recurrence more than two years of postoperatively.

DISCUSSION

Symptomology encountered in the thoracic outlet or neurovascular compression syndrome may include pain, paresthesia, weakness, swelling, numbness and, possibly, Raynaud's phenomenon in the upper extremity. Although all of these symptoms may be common to the thoracic outlet syndrome, they also may be the product of other conditions. In spite of the history and a careful physical examination, the precise diagnosis of a thoracic outlet compression syndrome may be difficult.[2] Chest roentgenograms, cervical spine films, neurological consultation and electromyography may be desired. Ulnar nerve conduction velocity studies are especially helpful in guiding any decision regarding therapy.[3]

We have employed the Doppler ultrasonic flowmeter as an initial screening technique in the evaluation of patients with a suspected thoracic outlet syndrome and prior to the possible employment of nerve conduction studies and arteriography.

The Doppler ultrasonic flowmeter is an electronic device by which pulsatile bloodflow may be detected transcutaneously.[4] The ultrasonic flowmeter consists of a probe with two piezoelectric crystals, one of which emits a beam of ultrasound when excited with the oscillator. The second crystal, of matched natural resonating frequency to the first, receives the sound after it has been emitted through intact skin with an ultrasonic gel and is backscattered from moving red blood cells. The frequency shift noted in those beams which have been backscattered from moving matter is amplified and presented as an audio signal or as an analog video signal. The Doppler is based on a physical principle first described by Djohann Christian Doppler, a 19th century Austrian physicist and mathematician. It has to do with changes in the frequencies of sound as the distance between the source and listener is rapidly varied.

The Doppler ultrasonic flowmeter has been used as a diagnostic tool in many vascular disorders and has proven itself to be a valuable adjuvant to the surgeon's armamentarium. The instrument is illustrated in this article as a simple method of gaining objective evidence when the patient presents symptomology suggesting a thoracic outlet compression syndrome. With the Doppler flowmeter, the surgical procedure performed also may be evaluated. The authors are from the Department of Surgery, University of Missouri School of Medicine.

The flowmeter has been used as a diagnostic aid and an operative tool in the evaluation and correction of carotid artery occlusive disease, the surgical treatment of arteriovenous fistula, the detection of microemboli during cardiopulmonary bypass and in cases of tissue viability assessment during trauma.[5–10]

SUMMARY

We have presented a simple method of gaining objective evidence when the patient presents symptomology suggesting a thoracic outlet compression syndrome. We have utilized this method because it does away with the false or paradoxical information provided by the palpating finger. The Doppler ultrasonic flowmeter has been used as a diagnostic tool in many vascular disorders and has proven itself to be a valuable adjuvant to the surgeon's armamentarium. In the aforementioned case, the flowmeter is used not only as an initial diagnostic aid but, at surgery, the Doppler provides important information concerning the hemodynamics of the vasculature involved. With the instrument, the surgical procedure performed may be evaluated by placing the extremity through a range of motion test. If the limb does not have normal arterial function when evaluated in a range of motion test with the ultrasonic flowmeter, the procedure can be modified at the original operation. This type of intraoperative evaluation diminishes the probability of reoperation for the same problem.[6]

Although first rib resection via the transaxillary approach is a most reliable and effective means of decompression of the neurovascular bundle, an occasional scalenotomy may suffice as accomplishing the same goal, providing careful intraoperative monitoring with the Doppler ultrasonic flowmeter is utilized.

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Management of Complications

(Continued from page 121)

during their postoperative period. The etiology of this is not clear. It has been self-limiting and transitory. It is our impression that multivitamin therapy has improved it.

Flatulence

Increased intestinal gas occurs in most patients who have had a (small bowel) bypass operation and each patient develops his own mode of therapy. The use of simethicone (Mylicon) tablets, Requa's Charcoal and avoidance of offending foods are of value.

Hemorrhoids, Anal Fissure and Anal Irritation

The passage of frequent diarrhea stools accentuates any preexisting anal pathology. Perianal irritation is best controlled by warm sitz bath and the use of diperodon hydrochloride (Diothane) ointment. Anusol H. C. suppositories are helpful. Fissurectomy and hemorrhoidectomy are carried out when indicated.

SUMMARY

Jejunal-ileal anstomosis, bypassing the small bowel, for the treatment of the morbidly obese state has been carried out on 350 patients. An analysis of the complications encountered and suggestions for therapy when these complications ensue have been described.

The American Board of Family Practice announces that it will give its next two-day written certification examination on October 19-20, 1974. It will be held in five centers geographically distributed throughout the United States. Information regarding the examination may be obtained by writing to Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Please Note: It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is June 15, 1974.

DONNA I. OSTHOFF *and* M. A. S. HALLABA, M.D., *Joplin*

Stroke Clubs: A National Survey

STROKE presently ranks as the third largest cause of death in this country and as a major disabling illness. Prevention and rehabilitation appear as the most effective way of combating this dreadful and tragic disease. Recent trends have included public education concerning the warning signs of impending stroke and the management of problems of poststroke victims. The formation of stroke clubs throughout the United States has been one means by which these needs are being satisfied. This article reviews their activities and presents suggestions on furthering their effectiveness.

FINDINGS

In a survey of known Stroke Clubs in the United States during the fall of 1972, 28 questionnaires were sent out and returned. Only 19 reports were reviewed for the purpose of this paper, the remainder being incomplete.

Club Names

Eight clubs are called Stroke Clubs and take their name from the location of the club, e.g., Galveston Stroke Club. This would seem best for simplification of communications on all levels. A variety of other names include Fun and Friendly Stroke Club and Post-Stroke Patients Association (See Appendix for list of stroke clubs).

Sponsorship

Sixteen clubs are sponsored and three are not. Sponsorships include local chapters of the American Heart Association (four clubs), Regional Medical Program (one club), Texas Institute for Rehabilitation and Research (one club) and Southeast Texas Health Foundation (one club). Nine clubs in the Pittsburgh area are sponsored by five different local associations, namely, the Visiting Nurses Association, the Young Men's and Women's Christian Association, Neighborhood Centers Association, Kingsley Association and Brashear.

Financial Support

Of the 16 sponsored clubs, four rely solely on the sponsoring agencies to provide financial support. The remaining 12 receive additional help through dues or donations or both. Two of the nonsponsored clubs apparently rely on dues or donations completely. The third receives refreshments and postage needs from a hospital and does not collect dues or donations. No clubs receive dues only. Seven receive donations only and nine receive both. Three receive neither. Some groups also have special money-raising projects. Donations include refreshments, money, films, equipment for stroke patients and books.

Funds have been used to purchase library books; hair dryer (for use of patients after routine EEG testing); refreshments; special patient expenses such as walkers, braces, clothing, medical costs, transportation, prizes and newsletter expenses; and other printing and postal expenses for educational materials and notices.

Membership

Club membership ranges from 20 to 250. The mean number of members is 44.6 per club. In four clubs, membership is open to all interested persons. In 14 clubs, members include stroke victims and

This article presents a review of the organization and activities of stroke clubs which have become operational in the United States in order to meet the educational and social needs of the stroke victim and his family. The authors discuss the success of stroke clubs in filling the gaps between the hospital and professional team and the stroke patient and his family. They suggest the formation of a national association of stroke clubs and provide a list of present stroke clubs in the United States. Ms. Osthoff is a Speech Pathologist and Dr. Hallaba is Project Director for a stroke program established at St. John's Medical Center on a grant from the Missouri Regional Medical Program.

families only. One club restricts its membership to selected stroke victims and their families for research purposes. Several clubs restrict voting and holding of offices to stroke victims although they do allow family and friends to participate in other club functions. This is done to encourage more participation by stroke victims.

Meetings

All clubs meet monthly for one to two hours except the nine Pittsburgh clubs which meet weekly for three to four hours. Hospitals, rehabilitation centers and churches provide 13 of the clubs with a meeting place. Various local associations have provided similar facilities for the other clubs.

Officers and Committees

Sixteen clubs have officers and three do not. Officers include president or chairman, secretary-treasurer or both, historian librarian and receptionist.

Fifteen clubs have committees. Types listed are visiting, program, social, telephone, library and transportation. In two other clubs, members informally assume the responsibilities of committees. As mentioned previously, some clubs restrict committee members to stroke victims. These clubs feel that stroke victims are encouraged to participate more in this way. Fifteen clubs have a program committee. Two clubs have informal planning committees. In the remaining two clubs, a professional worker is responsible for planning programs following suggestions from club members.

Type of Program and Activities

The questionnaire asked if programs are primarily educational, primarily social or both. One is reported educational, three social and 15 are both. Activities included range from the following:

A. **Educational:** Talks by speech, physical and occupational therapists, psychologists, neurologists, physicians, social workers, dietitians, radiologists, EEG technicians, personal accounts by club members, guest speakers such as Carmen McBride (author of *Silent Victory*), films and slides on or related to strokes.

B. **Social:** Events such as picnics or trips, fish fries, demonstration of and participation in hobbies (such as macrame, handmade Christmas decorations), participation in games, "gossip" sessions and talks on personal trips.

C. **Therapy:** Speech stimulation classes, voice exercises, eurhythmic programs and swimming.

Volunteers

Volunteers are used by the nine Pittsburgh clubs as general helpers at club meetings, but they function without formal written instruction. The stroke club in San Gabriel, Calif. is just starting a volunteer program. St. John's Medical Center in Joplin, Mo. has a volunteer program, but it is not operated by the stroke club in that region. However, several members of the stroke club do participate in this program. Volunteers are given a 40-hour training course for hospital and home therapy follow-up and family and patient support.

Discussion

The Stroke Club at St. John's Medical Center was activated in January, 1971, six months after the initiation of a Missouri Regional Medical Program Project for Stroke Prevention and Rehabilitation. The need for such an organization to assist the stroke victim and his family in resocialization and rehabilitation and to assist in filling the gap between hospital, professional team, family and patient became quickly apparent. The response of the public to stroke clubs formed throughout the country indicates the success with which the clubs are meeting this need. At Joplin, the Four State Stroke Club has a newsletter mailing list of 265 and a regular monthly attendance of 30 to 50 persons at club meetings.

Although all clubs have some form of publicity, including newsletters, radio and TV announcements, newspaper articles, personal calls and visits and posters, communication between the various clubs nationwide has been lacking. A question was raised about a national organization or affiliation. There was only one definite *no* response, whereas the remaining clubs were ambivalent or in favor of such an organization. The ambivalent feelings seemed to stem from uncertainty as to the structure and function of such an organization—questions which would have to be answered by representatives of various clubs in view of their needs and wants when a national association is being organized.

Conclusions

A national affiliation would seem to be the most efficient and unanimously agreed upon means to facilitate communications among stroke clubs. Such a central organization would allow for (1) accumulation and dissemination of information of interest to any and all clubs; (2) sharing of special articles, essays and listings written by club members;

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50 mg. phenylpropanolamine hydrochloride;
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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Indications**
Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.

Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

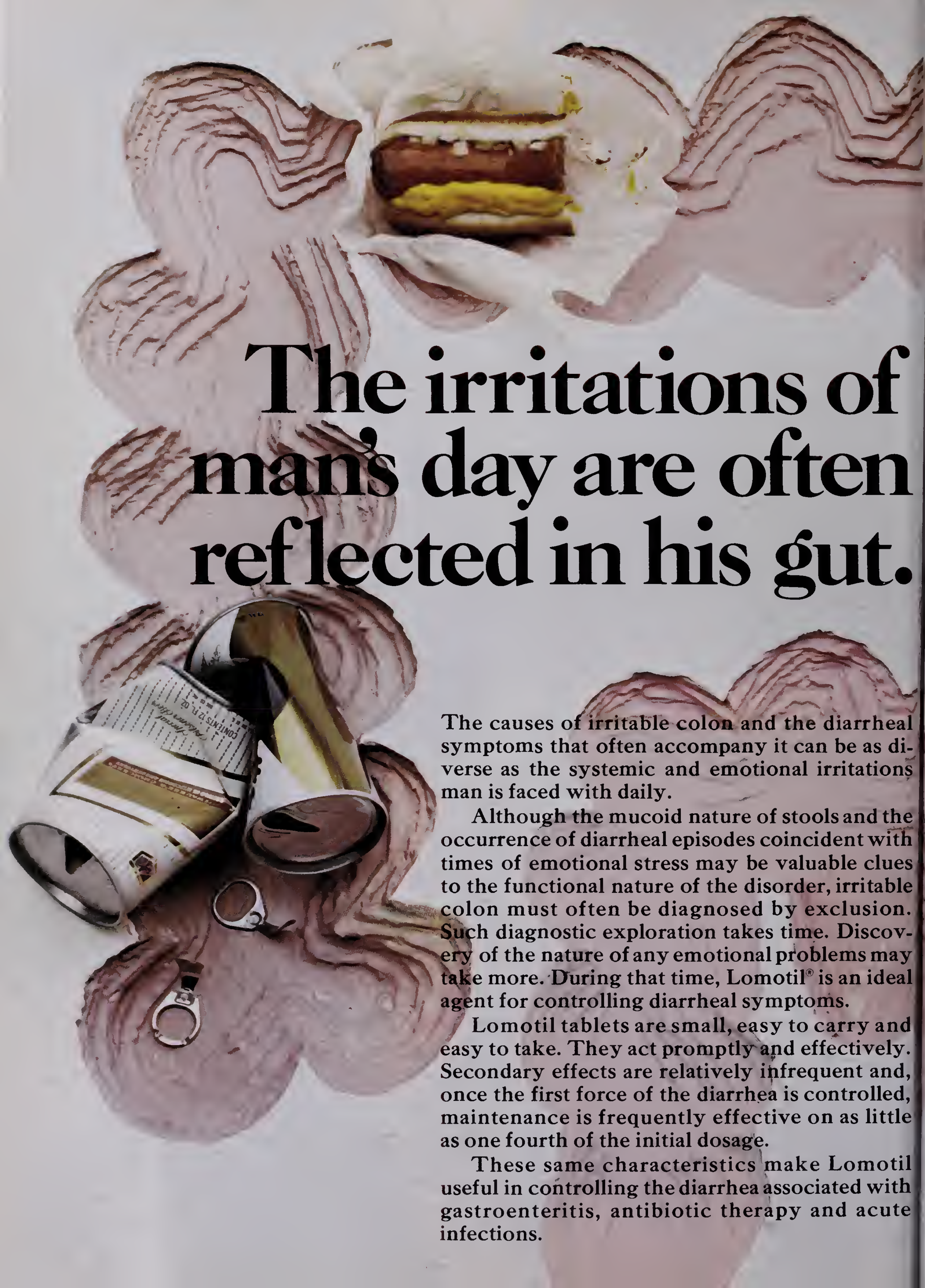
Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

SK&F Smith Kline & French Laboratories
Division of SmithKline Corporation, Philadelphia, Pa. 19101



The irritations of man's day are often reflected in his gut.

The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . 0.025 mg.

takes care of the gut issue in irritable colon

SEARLE

Searle & Co.
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co., Medical Department
Box 5110, Chicago, Illinois 60680

352

Man invented the wheel...

Then he invented
Antivert®/25 Chewable Tablets
(meclizine HCl 25 mg.)
for motion sickness

A single dose of Antivert (25 to 50 mg.) taken one hour before travel offers:

☐ effective control of nausea, vomiting and dizziness associated with motion sickness.
☐ long-acting antiemetic action that continues for up to 24 hours.
☐ Antivert/25 Chewable—available on your prescription only.

INDICATIONS. Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

(3) accurate listing of all clubs for referral of patients by physicians, social workers and therapists; (4) library facilities for more costly educational materials not provided by other agencies, such as films and slide presentations; (5) organization of regional meetings, workshops and conferences; and (6) publication of a national newsletter.

At the present time, several clubs are sponsored by the American Heart Association. It appears that affiliation with this organization, which is active nationwide as well as locally, would be the most logical and least expensive alternative. Furthermore, AHA sponsors regional meetings dealing with Cerebrovascular Disease and publishes an excellent journal entitled "Stroke."

Summary

Stroke Clubs throughout the country have been established primarily to meet the educational and social needs of the stroke victim and his family. They are typically sponsored, but collect dues or donations or both for assistance in support. Most groups meet for one to two hours monthly to share in activities planned by representatives of the clubs. Several clubs meet for therapeutic and social activities on a weekly basis. Average attendance is 44 persons, a good indication of the need and desire of stroke victims and families for such clubs. Typically, clubs have officers and formal or informal committees. Volunteers are used by several clubs, but formal volunteer programs have not been set up as a part of any clubs. Better communication between clubs is needed and desired. Affiliation with the American Heart Association appears to be the most logical means of bridging this gap.

Appendix

ALABAMA

Myrne E. Ely
Mobile Rehab. Assn.
1874 Pleasant Ave.
Mobile, Ala. 36617

CALIFORNIA

Mrs. Emily Hackler, R.N.
RMP Area VIII, V. of Calif. Medical School
2021 Business Center Dr.
Irvine, Calif. 92664
(RMP Volunteer Program Director)

Mrs. Joan Mitchell, R.N.
Community Hospital of San Gabriel
218 S. Santa Anita
San Gabriel, Calif. 91776

FLORIDA

Mrs. Grace Lanning, R.N.
Associate Director
Florida Heart Assoc. Inc.
2828 Central Ave.
P.O. Box 10100
St. Petersburg, Fla. 33712
(813-894-6865) Spn. 5 clubs

GEORGIA

Miss Debbie Leberman
Speech Pathologist
Men's Stroke Group
Easter Seal Society
1362 West Peachtree, N.W.
Atlanta, Ga. 30309

Mrs. Peg Wagner, Secretary
Community Cardiovascular Council
612 Drayton
Savannah, Ga. 31401

HAWAII

Mr. Jerry Conovder
Coronary Club of Honolulu
c/o Hawaii Heart Association
245 Kukui St.
Honolulu, Hawaii 96813

ILLINOIS

Mrs. Muriel Belson
Henner Hearing & Speech Center
Michael Reese Hosp. & Med. Center
29th St. & Ellis Ave.
Chicago, Ill. 60616

Return Unlimited Clubs
c/o Miss Donna Brandon, R.N.
Ill. Heart Association
P.O. Box 2666
1181 N. 31st St.
Springfield, Ill. 62705

INDIANA

Lafayette Stroke Club
2840 Barlow St.
West Lafayette, Ind. 47906

LOUISIANA

Mrs. Anne Haskridges, O.T.
U. S. Public Health Service
210 State St.
New Orleans, La. 70118

MINNESOTA

Laura McLean, C.O.T.A.
Hopkins Nursing Home, Inc.
724 Country Road No. 18
Hopkins, Minn. 55343

MISSOURI

c/o Sandy Grundeman
Kansas City Stroke Club
Spon. by K.C. Heart Assoc.
19 Upper Mall
3600 Broadway
Kansas City, Mo.

Midland Empire Stroke Club
Family Guidance Center
213 Corby Bldg.
St. Joseph, Mo. 64501
c/o Diane Barnes

Lorretta Cartwright
Four State Region Stroke Club
2727 McClelland Blvd.
Joplin, Mo. 64801

NEW HAMPSHIRE

The Lakes Region Aphasia & Stroke Association
The Langston Special Ed. Center
968 North Main
Laconia, N. H. 03246

NEW YORK

Dr. Marion Emerson
Community Stroke Group
Rehabilitation Unit
Strong Memorial Hospital
Rochester, N. Y. 14620

c/o Mr. Julius Lombardi, Sec.
Post-Stroke Patients Assoc.
119 Arrow St. South
Schenectady, N. Y. 12304

OHIO

"The Five County Stroke Club"
Mrs. Mary Ann Bullinger (Pres. Ch.)
417 Oaklawn
Fremont, Ohio 43420

The Strokers
Northwestern Ohio Heart Chapter
American Heart Association
215 Community Services Bldg.
1 Stranahan Square
Toledo, Ohio 43604

PENNSYLVANIA

Mrs. Marie Hamilton
Visiting Nurse Association of Allegheny County
815 Union Place
Pittsburgh, Pa. 15212
(Mrs. H. is the Coordinator of the Stroke group)

TENNESSEE

Mrs. Ruth Allen Smith, R.N.
Daniel Arthur Rehab. Center
Oak Ridge, Tenn. 37830

TEXAS

Wini Breitback, R.N.
The Methodist Hospital
6516 Bertner
Houston, Tex. 77025

Mrs. Yvonnie Johnson, President
Houston Stroke Club
St. Anthony's Center
6301 Almeda Rd.
Houston, Tex. 77021

Mrs. Duane Kerr, O.T.R.
Rosewood Hospital
9200 Westheimer
Houston, Tex. 77042

Riccardo J. Tettamanti
Stroke Research Founders Club
Texas Inst. for Rehab. & Research
1333 Moursund Ave.
Texas Medical Center
Houston, Tex. 77025

Laura L. Reed, O.T.R.
Easter Seal Society
617 Seventh Ave.
Fort Worth, Tex. 76104

Mrs. Jerry Stedman
Southwest Texas Health Foundation
650 Main
Beaumont, Tex. 77701

Mr. Ellis Williamson, President
Galveston Stroke Club
805 12th St.
Galveston, Tex. 77550

Mrs. Vera Vahalik
Rt. 4, Box 176H
Victoria, Tex. 77901

At Your Service in The Show Me State

In the state about whose citizens Congressman W. D. Vandiver in 1899 said: ". . . frothy elegance neither convinces nor satisfies me. I am from Missouri. You have got to show me." . . .

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MARION
LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

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Sam Eismont

Fred Hastie

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John Hinz

Bruce Jackson

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Clay Joseph

Shelby Sharpe

Will Triplet

These men bring you . . .

Puts comfort in your prescription for nicotinic acid

Description: Each capsule contains 400 mg of nicotinic acid in a special base that provides a prolonged systemic effect.
Indications: NICO-400™ is recommended for all disease states in which nicotinic acid has been used. These include conditions associated with deficient circulation and for use in the correction of nicotinic acid deficiencies.
Contraindications: Individuals with a hypersensitivity to nicotinic acid, severe hypotension or hemorrhaging.
Warnings: Use with caution in those patients with history of peptic ulcer, severe diabetes, impaired gall bladder or liver functions and in pregnant women.
Adverse Reactions: Patients should be informed of the short-lived reactions experienced with nicotinic acid therapy: cutaneous flushing, a sensation of warmth, tingling and itching of the skin, increased gastrointestinal motility and sebaceous gland activity.
Dosage and Administration: One capsule every 12 hours or as directed by physician. Caution: Federal law prohibits dispensing without prescription.
How Supplied: Bottles of 100 capsules.

Marion patient benefit product from

MARION

THE OPTIMAL DOSE, 400-mg, timed-release NICO-400® (nicotinic acid) capsule provides

- Controlled flushing for the desired effects without therapy-limiting side effects.
- Convenient b.i.d. dosage that's less likely to be forgotten.
- The economy of nicotinic acid medication.

For comfort wherever nicotinic acid is used

NICO-400®

(nicotinic acid) Plateau CAPS®

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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MeadJohnson LABORATORIES

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

President's Message

The spiraling expense of medical liability insurance is, perhaps, the one thing that causes more concern to physicians than PSRO and other government interference.

Since the beginning of history, there has been the problem of liability for the physician. The Code of Hammurabi provided that the clumsy surgeon might lose his hand as penalty for an operation resulting in injury to a patient. The Mosaic Law called on a careless physician to repay an eye for an eye. Modern civilization, however, "protects" a negligent physician through the use of monetary payments for patient damage when the treating physician is proved at fault.

E. A. Stricker, M.D.

In 1914, Judge Cardozo, then a member of the New York Court of Appeals, wrote, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable for damages." Failure to warn or advise the patient of dangers, risks or possible adverse results is the basis for the patient's claim in court. The action for malpractice is grounded primarily on patient's lack of Informed Consent.

The amount of material facts reasonably necessary for the patient to be informed varies considerably from state to state and from court to court. Most courts insist that the physician's conduct be judged by the prevailing standards of physicians in the community.

It is of increasing concern to each doctor when he receives his malpractice insurance premium and finds that it is $300 to $500 higher—without suit ever having been brought against him. But, there *are* increasing numbers of medico-legal litigations.

Since there is a much higher incidence of malpractice claims along the east and west coast areas, it seems reasonable that the more stable central areas—we in Missouri, in particular—should have lower insurance rates. Here is another place where the MSMA could be of assistance. Our association could set up a statewide liability insurance program which should lower the rates to all doctors in Missouri.

In the meantime, let's all be alert to the medico-legal pitfalls.

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

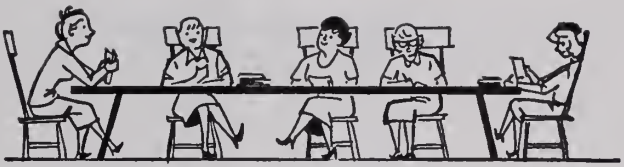
Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and $\frac{1}{32}$ oz. (approx.) foil packets.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Woman's Auxiliary

50th Anniversary



A HAPPY ANNIVERSARY!

The Woman's Auxiliary to the Missouri State Medical Association will celebrate the beginning of its 50th year at its 49th Annual Meeting which will be held in conjunction with the MSMA Annual Session on April 4-7 in Kansas City at the beautiful Crown Center Hotel.

This is a special invitation to your wife to come to our meeting, get acquainted with our officers and members from other communities and take part in our activities. Will you please relay our invitation to her and encourage her to attend?

Mrs. Charles R. Willman
President

Since this is our first meeting at the Crown Center Hotel, we have tried to streamline the format so that all members will have time to participate in the Auxiliary program as well as shop in the unusual Crown Center stores. Following the business meeting on Friday morning, there will be a luncheon at noon in honor of Mrs. Howard Liljestrand from Hawaii, President-Elect of the Woman's Auxiliary to the American Medical Association. Other special guests will be MSMA President E. A. Stricker, who will extend greetings, and members of the MSMA Advisory Council to the Auxiliary. Mrs. W. Nash Thompson of Nashville, Tenn., president of the Southern Medical Association Auxiliary, also will be there to extend greetings.

We invite you to attend a reception honoring Mrs. George J. Lytton, our President-Elect, on Friday evening.

Our second Annual Public Affairs Breakfast is scheduled for 7:30 AM Saturday. Dr. John Chenault, a member of the AMA Board of Trustees, will be the speaker. We urge all members of the MSMA to attend with your wives to hear Dr. Chenault.

Our Birthday Party will be a luncheon on Saturday in honor of all MSMA Auxiliary Past-Presidents, a highlight of our meeting and certain to be a memorable occasion. The 50th Anniversary Committee has worked during the past year to prepare a special program reviewing the Auxiliary's 50-years.

We will pay tribute to *Mrs. Willard Bartlett,* who presented the idea of organizing a Woman's Auxiliary to the MSMA House of Delegates in May, 1924. The House appointed her as State Organizer that year and she served as State President in 1928-1929. We also will honor *Mrs. Arthur B. McGlothlan,* who is the oldest living Past-President of the Woman's Auxiliary to the MSMA. Mrs. McGlothlan served as President of the Buchanan County Auxiliary in 1924-1926, the MSMA Auxiliary in 1926-1927 and the Woman's Auxiliary to the American Medical Association in 1931-1932.

We are especially proud to announce that the Woman's Auxiliary is publishing in book form a 50-year history entitled "50 Years of Service." It was compiled and written by eight Past-Presidents and will be available at the Annual Meeting.

So, please be a part of our celebration of *"50 Joyous Years of Service"* as we enthusiastically begin our next 50 years of service in Kansas City.

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

The annual "heart" program of the Buchanan County Medical Society was held at the Ramada Inn in St. Joseph following a dinner and business meeting on February 6.

The St. Joseph Heart Council sponsored the program. The speaker was George C. Kaiser, M.D., professor of surgery, St. Louis University School of Medicine. Dr. Kaiser spoke on "Complications of Myocardial Infarction: Surgical Treatment."

Guests at the meeting were Mr. Watson Dersham, Executive Vice-President of the Missouri Heart Association, and Mr. Anthony R. Colgan, Northwest Missouri Regional Consultant for the Heart Association.

Program arrangements were made by the Program Committee with Dr. Edward M. Beheler, Chairman, and Drs. Edward H. Andres and Robert R. Stuber. Dr. Randal W. Weed, President, presided at the session. Dr. Beheler introduced Dr. Kaiser.

John T. Rogers, M.D., *Secretary*

Clay County Medical Association

The Clay County Medical Association installed officers at the President's Dinner at Rodeway Inn in North Kansas City on January 29.

Officers for 1974 are Drs. Felix A. Pileggi, President; Richard C. Hedges, President-Elect; Donald A. Fakhoury, Vice-President; Howard D. Adams, Secretary-Treasurer; and Van M. Robinson, Chairman, Board of Censors.

Guest speaker for the evening was Stanley S. Peterson, M.D. of Springfield who discussed physicians' unions.

The Clay County Medical Association executive office services are now being handled by the executive office of the Jackson County Medical Society. Mr. Roger Weis of the Society's staff has been designated the Clay County Association's Executive Secretary.

THIRD DISTRICT

COUNCILOR
MAX S. FRANKLIN, M.D., ST. LOUIS

St. Louis Medical Society

Dr. Richard V. Bradley was installed as the 139th President of the St. Louis Medical Society in ceremonies at the Society's headquarters building in January.

Dr. Bradley replaces outgoing President, Dr. Donald R. Judd.

Others who took office at the meeting were Drs. Francis X. Lieb, Vice-President; August W. Geise, Jr., President-Elect; and Carol F. Williams, who began her second term as Secretary.

The St. Louis Society also installed four Councilors for three-year terms. They are Drs. William C. Banton, George Bohigian, Lawrence M. Lawton and Leo J. LeBlanc.

Dr. Jack R. Eidelman was installed to a three-year term as a board member for the St. Louis Society for Medical and Scientific Education, a charitable sister-organization to the St. Louis Medical Society.

FOURTH DISTRICT

COUNCILOR
LOUIS P. HETLAGE, M.D., TROY

St. Louis County Medical Society

Dr. Frederick D. Peterson is the new president of the St. Louis County Medical Society. Other new officers installed at the Society's annual dinner-dance in January at the Algonquin Golf Club are Drs. John Laird, President-Elect; Morris Marcus, vice-president; and Jules Kopp, Secretary.

Dr. Emil A. Stricker of St. James, President of the MSMA, acted as the installing officer.

SIXTH DISTRICT

COUNCILOR
WILLIAM D. BRADSHAW, M.D., CLINTON

Pettis County Medical Society

The Pettis County Medical Society selected officers for 1974 at its annual holiday meeting in December at Maxine's Gourmet House.

New officers are Drs. A. L. Lowe, President; E. H. Van Dyke, President-Elect; William R. Cole, Secretary; and H. F. Daum, Treasurer.

Dr. J. E. Block, Immediate Past-President, will continue to serve as a Delegate to the MSMA House of Delegates.

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Butler-Wayne-Ripley County Medical Society

The Butler-Wayne-Ripley County Medical Society held its regular meeting on Oct. 9, 1973 at the Hickory House Restaurant in Poplar Bluff.

The following members were elected as officers and delegates to the MSMA Annual Session for 1974: Drs. Ricardo M. Ramirez, President; Tom Wood, Vice-President; D. K. Varma, Secretary; and Robert H. Laatsch, Treasurer.

Elected as Delegates to the MSMA Annual Session were Drs. George H. Ladyman, T. Eugene Ruff and Fred Caldwell. Alternate Delegates are Drs. Austin R. Tinsley, Bennie N. Till and S. K. Reddy.

After the election, Dr. Ramirez presented a taped program on legal problems entitled “Emergency and Outpatient Care” by Mr. Crawford Morris, an attorney.

Members present at the meeting were Dr. W. Alexander Hoja, Dr. Barry B. White, Dr. Delbert E. Tiffany, Dr. A. N. Reddy, Dr. Tinsley, Dr. E. C. Carlson, Dr. Joseph E. Hecker, Dr. Laatsch, Dr. Ruff, Dr. Marvin R. Barbour, Dr. Reddy, Dr. Ladyman, Dr. Ramirez and Dr. Caldwell.

T. O. Wood, M.D., *Secretary*

Mineral Area Medical Society

The first 1974 meeting of the Mineral Area Medical Society was held on January 31 in the Hoctor Building at the Farmington State Hospital.

The scientific program consisted of a presentation of a film, “GI Rounds,” produced by Medcom and presented by Merrell Laboratories.

The business meeting was conducted by President Norma Farmer. The minutes of the meeting on October 25 were read and approved. On motion of Dr. Robert F. Dettmer, seconded by Dr. Charles H. Appleberry, Dr. Metin Arat of Farmington was nominated for election as Vice-President (a post which had not been filled in October). This motion passed unanimously.

Correspondence included the report of the meeting the previous week of the Commission on Medical Economics of the Missouri State Medical Association, which was attended by Dr. Charles W. Chastain.

Members of the Society approved two resolutions to be introduced at the 116th Annual Session of the Missouri State Medical Association.

Dr. Appleberry moved and Dr. Huckstep seconded that the Mineral Area Medical Society go on record in opposition to the proposal for preadmission certification, a procedure whereby Medicaid and Medicare patients could not be admitted to hospitals except under emergency conditions without the approval of a special committee, and instructed the Secretary of the Society to send letters to our senators and representatives protesting these federal regulations and urging their repeal. The motion passed unanimously.

Members present included Drs. Alvan G. Karraker, F. Richard Crouch, Juan Cancelada, George A. Oliver, Carlos J. Borremeo, Javier A. Pichardo, Emmett F. Hoctor, Marvin C. Menne, R. A. Huckstep and N. K. Datta. Guests at the meeting were Mr. Bruce Pegram, a fourth-year medical student at the University of Missouri, and Mr. John Johnson of Merrell Laboratories and Mr. Edward Klein, of Medical Arts Pharmacy.

C. W. Chastain, M.D., *Secretary*

In Memoriam

Raul Huet, M.D., 2625 West Pasco, Kansas City, a graduate of the University of Mexico, 1950; member of Jackson County Medical Society; age 49; died Jan. 4, 1974.

Frank S. Hogue, M.D., 4320 Wornall Rd., Kansas City, a graduate of the University of Kansas, 1930; member of Jackson County Medical Society; age 68; died Jan. 10, 1974.

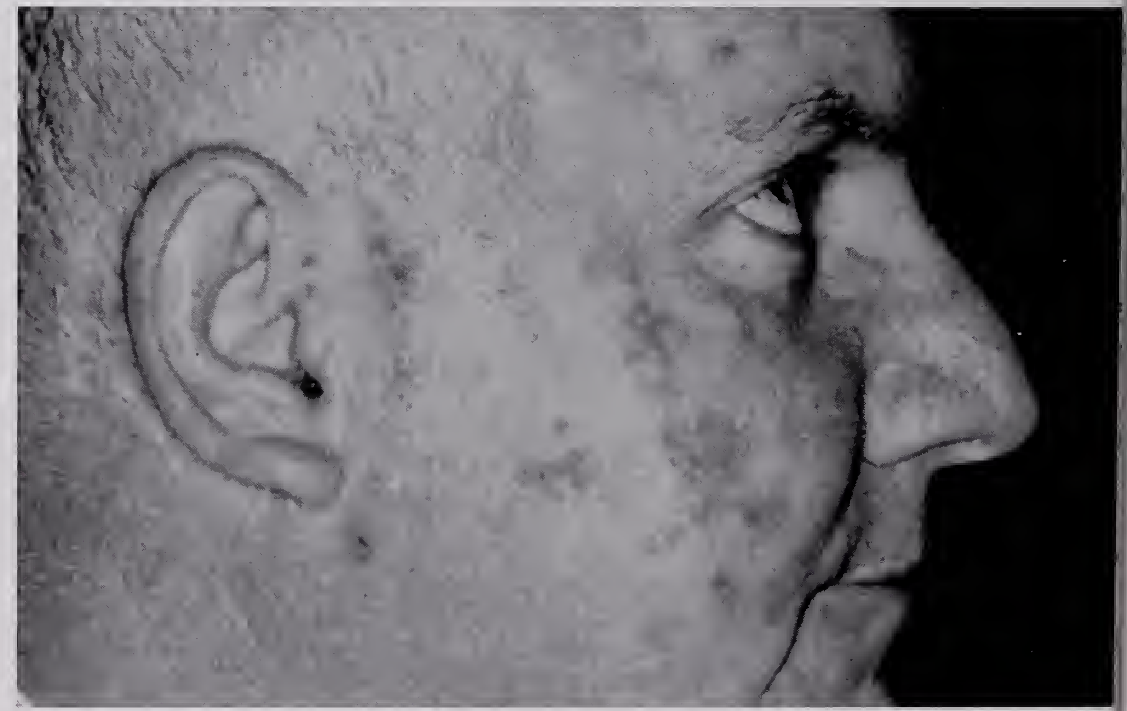
A. N. Vaughn, M.D., 4500 Olive, St. Louis, a graduate of Meharry Medical College, 1917; member of St. Louis Medical Society; age 83; died Jan. 27, 1974.

Edward P. Reh, M.D., 6744 Clayton Rd., St. Louis, a graduate of St. Louis University, 1936; member of St. Louis Medical Society; age 62; died Feb. 6, 1974.

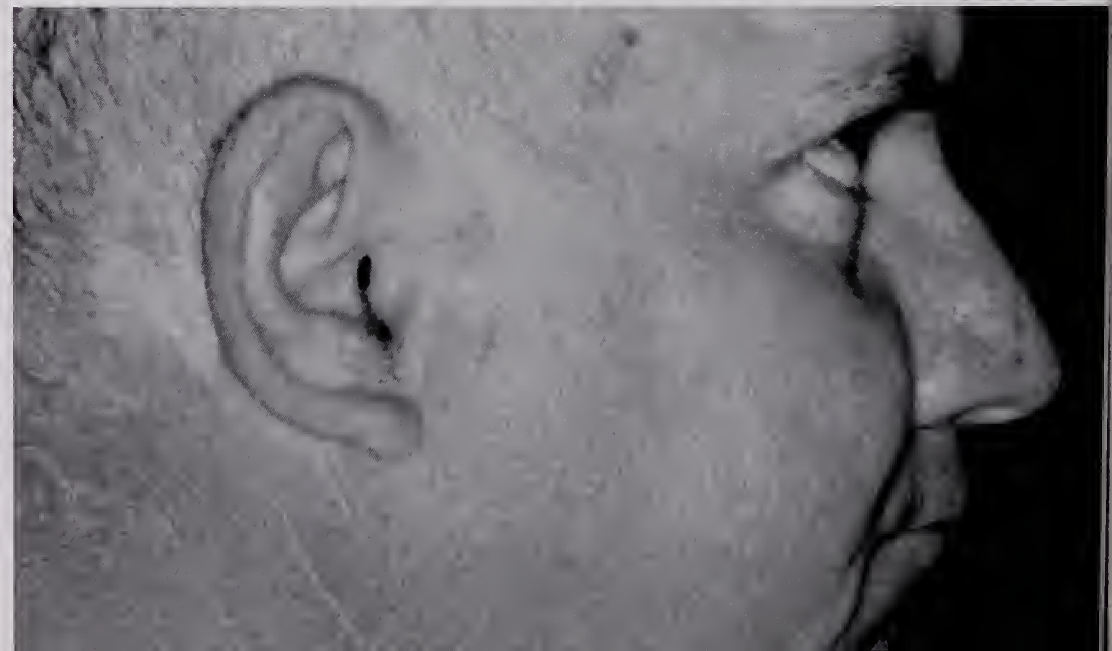
What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.



*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

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Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

This patient's lesions were resolved with

Efudex®

fluorouracil/Roche®

5% cream/solution...a Roche exclusive

Continuing Education Coming Events

March 29-30	**The Long Weekend: Cardiovascular Disease I and II** University of Missouri-Kansas City and Kansas City Southwest Clinical Society Crown Center Hotel, Kansas City
April 10-11	**20th Annual Urology Seminar** University of Missouri-Columbia Medical Center and Extension Division with cooperation of Kansas City Urological Society Crown Center Hotel, Kansas City
April 15-17	**Symposium: Ophthalmology: Diagnosis and Treatment of Orbital Diseases** Postgraduate Medical Education K.U. School of Medicine, Kansas City, Kan.
April 22-23	**Symposium: Recent Advances in Obstetrics and Gynecology** Clompton Auditorium, Washington U. School of Medicine St. Louis
April 25-26	**Workshop: Clinical Approach to Allergic Disorders** St. Louis U. Medical Center Continuing Education Miller Hall, St. Louis
April 26	**Symposium: Infectious Diseases** Postgraduate Medical Education K.U. School of Medicine, Kansas City, Kan.
May 13-16	**Symposium: Basic Electrocardiography** Postgraduate Medical Education K.U. School of Medicine, Kansas City, Kan.
May 15-16	**1974 Spring Clinical Conference: Fundamental Cardiology** Continuing Medical Education M.U. Medical Center, Columbia
May 17-18	**Course in Medicine and Surgery** The Jewish Hospital and Washington U. School of Medicine The Jewish Hospital of St. Louis, St. Louis
May 23-24	**Symposium: Mild and Moderate Hypertension** Washington U. School of Medicine Continuing Medical Education Stouffer's Riverfront Inn, St. Louis
June 5	**Seminar: Evaluation of Acute and Chronic Gastrointestinal Bleeding** The Ed Bixby Institute for Postgraduate Medical Education Research Hospital and Medical Center Kansas City
May 24	**12th Annual Pediatric Seminar: Pediatric Endocrinology** Baptist Memorial Hospital, Kansas City

New Members

Luke J. Dlabal, Jr., M.D., 4240 Blue Ridge, Kansas City, has become a member of Jackson County Medical Society. Dr. Dlabal is a native of Kansas City, received his preliminary education at Rockhurst College and his M.D. degree at the University of Missouri-Columbia in 1966. He specializes in otorhinolaryngology.

Lawrence D. Henry, M.D., 2703 Clark La., Columbia, has become a member of Boone County Medical Society. Dr. Henry is a native of Dow City, Ia., received his preliminary education at the University of North Carolina and his M.D. degree at the University of North Carolina in 1966. He specializes in pathology.

Marijan Herjanic, M.D., 1420 Grattan, St. Louis, has become a member of St. Louis County Medical Society. Dr. Herjanic is a native of Yugoslavia, received his M.D. degree at the University of Zagreb in 1956. He specializes in psychiatry.

John W. Heryer, M.D., Warnall Rd. at 44th, Kansas City, has become a member of Jackson County Medical Society. Dr. Heryer is a native of Kansas City, received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1972. He specializes in surgery.

Lawrence E. Koppers, M.D., 6400 Prospect, Kansas City, has become a member of Jackson County Medical Society. Dr. Koppers is a native of Humboldt, Kan., received his preliminary education at Rockhurst College and his M.D. degree at the University of Kansas in 1966. He specializes in endocrinology.

Duk S. Lee, M.D., 1130 Cantina Dr., St. Louis, has become a member of St. Louis Medical Society. Dr. Lee is a native of Korea, received his preliminary education at the College of Liberal Arts and Sciences and his M.D. degree at Seoul National University in 1960. He specializes in anesthesiology.

Newton C. McCluggage, M.D., 2700 Hospital Dr., Kansas City, has become a member of Clay County Medical Society. Dr. McCluggage is a native of Lawrence, Kan., received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1965. He specializes in internal medicine.

E. Jane Mauch, M.D., 900 E. Adams, Nevada, has become a member of West Central Medical Society. Dr. Mauch is a native of Sapulpa, Okla., received her preliminary education at the University of Oklahoma and her M.D. degree at the University of Iowa in 1970. She specializes in family practice.

William V. Miller, M.D., 4901 Washington, St. Louis, has become a member of St. Louis Medical Society. Dr. Miller is a native of Kansas City, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1966. He specializes in clinical pathology.

Arturo H. Montellano, M.D., 808 Euclid, Monett, has become a member of Ozark County Medical Society. Dr. Montellano is a native of Baco, Or. Mindoro, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1965. He specializes in obstetrics and gynecology.

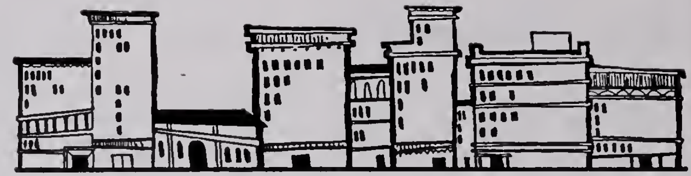
Romulo G. Perez, M.D., 415 E. Cherry, Troy, has become a member of St. Charles-Lincoln County Medical Society. Dr. Perez is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1962. He specializes in obstetrics and gynecology.

Luzviminda F. Sicat, M.D., 414 Ladue Rd., Jefferson City, has become a member of Cole County Medical Society. Dr. Sicat is a native of Manila, Philippines, received her preliminary education at the University of Santo Tomas and her M.D. degree at the University of Santo Tomas in 1964. She specializes in radiology.

Austin R. Tinsley, M.D., 2nd and Oak, Poplar Bluff, has become a member of Butler-Wayne-Ripley County Medical Society. Dr. Tinsley is a native of St. Louis, received his preliminary education at the University of Missouri-Columbia, and his M.D. degree at the University of Missouri-Columbia, in 1972. He specializes in family practice.

Gerardo G. Vergara, M.D., 31st and Wyandotte, Kansas City, has become a member of Jackson County Medical Society. Dr. Vergara is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1964. He specializes in pathology.

From the Medical Schools



ST. LOUIS UNIVERSITY

Dr. Herbert B. Taylor has been named chairman of the Division of General Pathology. Dr. Taylor, professor of pathology, formerly served as acting chairman of the Department of Pathology.

Dr. Taylor

Dr. Taylor earned the B.S. and M.D. degrees at the George Washington University and took his internship and residency training at the George Washington Hospital. He was with the Armed Forces Institute of Pathology as assistant pathologist from 1958 to 1959 and associate pathologist from 1959 to 1961. He continued as senior pathologist at the Institute from 1961 to 1970, when he joined the medical faculty at St. Louis University as professor of pathology.

Trustees and former trustees of St. Louis University have pledged more than $3.1 million toward the University's 1974-1978 $45 million development campaign. *Daniel L. Schlafly,* chairman of the board, made the announcement.

The pledges will go toward matching a $20,000,000 challenge endowment grant made by the Danforth Foundation last year. The matching $20 million the University will seek in the next five years will be primarily for unrestricted purposes such as faculty salaries. The Danforth grant is restricted to endowment.

In addition to the trustees' personal pledges, firms and foundations contributing to the total pledge are the Anheuser-Busch Charitable Trust, American Investment Co. Foundation, Donald L. Barnes Foundation, New York 7-Up Bottling Co. (John and Mary H. Joyce Foundation), St. Louis Clearing House Association, Southwestern Bell Telephone Co., Brown Group, Inc. Charitable Trust, Monsanto Fund, St. Louis Union Trust Co. Charitable Trust, Ramsey Corp. and the Edison Brothers Stores Foundation.

Six prominent St. Louis businesses, headed by *August A. Busch, Jr.*, will lead the five-year campaign. Busch will serve as honorary chairman for the five years. General chairman for 1974 is *Charles H. Sommer,* chairman of the board, Monsanto Co.

St. Louis University Medical alumni are invited to attend a reception in the Shawnee Room of the Crown Center from 5 PM to 6:30 PM on Saturday, April 6 during the annual meeting of the Missouri State Medical Association. *Dr. George E. Thoma,* vice-president for the Medical Center, and *Dr. Robert H. Felix,* dean, School of Medicine, will be on hand to greet alumni.

UNIVERSITY OF MISSOURI-COLUMBIA

Several members of the faculty in the Department of Medicine at the Medical Center were invited to present results of their research at the 28th annual meeting of the Southern Society for Clinical Investigation in New Orleans in January.

Representing the Division of Cardiology, *Drs. Richard Martin, Linley Watson, John Stone* and *George Reed* reported on "Pump Failure Complicating Myocardial Infarction: Clinical and Hemodynamic Features."

Two papers were presented by the Division of Gastroenterology: "Gastric Ethanol Clearance" by *Dr. Daniel Winship, Timothy J. Shuck* and *C. D. Winship;* and "Effect of Frequency of Feeding Upon Biliary Lipid Output" by *Drs. Kenneth Hanson* and *James Butt.*

The Division of Immunology/Rheumatology reported on "Relative Diagnostic Value of Different Antinuclear Antibodies in Old Age" by *C. F. Manning, J. A. Woltjen, Dr. Edward Adelstein* and *Dr. A. D. Morris.* "Effects of Vasectomy and Vasoligation on Immune Responses to Sperm and Fertility in Strain 13 Guinea Pigs" was reported by *Drs. William S. Irvin, M. Akimoto, Ian Thompson* and *Gordon C. Sharp. Drs. R. J. Samaha* and *W. S. Irvin* reported on "A Model of Deoxyribonucleic Acid (DNA) as Antigen Based on Biochemical and Radioactive Binding Data."

Drs. Oral E. Bass, Karl D. Nolph and *John F. Maher* of the Division of Nephrology reported on "Acute Effects of Hemodialysis on Removal of Intracellular Solutes."

WASHINGTON UNIVERSITY

Three Washington University School of Medicine faculty members have been awarded grants totaling $231,264 by the American Cancer Society.

A five-year, $135,000 Faculty Research Award was given to *Robert H. Allen,* M.D., assistant professor of medicine, to support his study on the isolation and characterization of human proteins that bind Vitamin B12 and help in their absorption from the intestine. After they are transported to cells within the body, the mechanisms by which normal and malignant cells take up and utilize Vitamin B12 will be studied in an attempt to develop new forms of treatment for cancer patients.

Joseph M. Davie, M.D., Ph.D., associate professor of pathology and of microbiology, was granted $62,500 for research of "Isolation of 'Binding Site' Mutants of Mouse Plasmacytomas." This study is of tumors which come from plasma cells. The focus will be on the area of the cell where the antibodies bind only with the antigens that stimulate their production.

A $33,764 grant to study cancer in children was received by *Abdel S. Ragab,* M.D., assistant professor of pediatrics. The support is for a project, "The Cryopreservation of Granulopoietic Marrow Stem Cells From Children With Acute Leukemia and Solid Tumors." This study will focus on improving the procedure of removing bone marrow stem cells from children with cancer and keeping them viable yet dormant by freezing. These cells will then be used for treatment as the cancer progresses.

Scientific Sessions Important to Every Physician!

116th MSMA ANNUAL SESSION

April 4-7, 1974   Kansas City   Crown Center Hotel

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St. Louis, Mo.

Topeka — Kansas City — Wichita

The Council Reports

(Continued from page 118)

Building Expenses	12,855
MMPAC Educational Funds	3,000
Council Special Contingency Fund	5,000
TOTAL	$367,523

On motion of Dr. Hetlage, duly seconded, the report of the Budget Committee was accepted, including those specific recommendations of Dr. Judd relative to Council expenses and to the payment of portions of the services by the Foundation and, further, to instruct Dr. Judd to proceed with further developments to utilize the funds for MMPAC.

Discussion then followed regarding the decrease in Journal advertising and who might be approached regarding such. Mr. Swarens indicated that in the past two months, many letters have been written to banks, investment companies, leasing firms, etc. explaining what our Journal has to offer. We have received some replies showing interest. However, no commitments have been made. Mr. McIntyre then explained how we receive most of our advertising through an advertising bureau which handles the layouts, contracts, etc. The Bureau has certain standards set up regarding the type of advertising it will accept for its 35 medical journal members.

REPORTS OF DISTRICT COUNCILORS

District #3—Dr. Franklin said that election of officers was held for the St. Louis Medical Society with the following results: Dr. August W. Geise—President-Elect; Dr. Francis X. Lieb—Vice President; and Dr. Carol F. Williams—Secretary. Installation of officers will be held on January 5, at which time Dr. Richard V. Bradley will be installed as President of St. Louis Medical Society.

The Council of the St. Louis Medical Society approved the Blue Shield Panel Plan since it has been revised.

The State Board of Healing Arts recently held a three-day examination in the St. Louis Medical Society Building.

Dr. Franklin stated that *St. Louis Medicine*, the Society's Journal, has modified and improved its appearance.

Dr. Franklin reported that the St. Louis Medical Society with the First National Bank of St. Louis is working on a plan to be able to transfer dues once weekly if the State Association will approve this type of action. Mr. Hollister Smith reported that some other societies are doing this. He stated, however, that it could not be done in 1974. It is felt that this could definitely shorten the time span between the time a physician pays his dues to the county and they are submitted to MSMA and then on to the AMA. In this manner, the bank could send dues directly to MSMA and to AMA on a regular schedule.

On motion, duly seconded, the Council approved St. Louis Medical Society's implementation of this plan.

Dr. Franklin stated that he had received a letter from a physician seeking approval for use of credit cards for patients to pay their physician. He said many physicians are now doing this and the AMA has approved it. A letter will be sent indicating this to the physician.

Resolution #9—"Health and Hospital Insurance for Newborn," which was passed by the 1973 MSMA House of Delegates, was brought up and the St. Louis Medical Society feels that this should be carried out. The Pediatric Association of Missouri will prepare such legislation and the St. Louis Medical Society Council hopes that the State Council will back it. Dr. Matthews stated that there is such a proposed bill and the Legislative Committee would be considering it at their luncheon meeting.

District #5—Dr. Bregant reported that the Fifth District has been primarily trying to educate every physician within the area regarding the Foundation concept.

District #10—Dr. Hansbrough reported that the physicians in his area recently received the papers which, when signed, will officially make them members of the Southeast Missouri Health Care Foundation. The Foundation expects to be in business soon. Many carriers are interested in submitting policies and, of course, the insurance programs must be approved. Dr. Hansbrough indicated that the Board of Directors of the Southeast Missouri Foundation are all physicians.

Discussion followed regarding the Southeast Missouri Health Care Foundation and concern was voiced over the possibility that an organization such as UNIMED, who set up the SEMHCF, might become quite powerful if it set up many foundations.

Dr. Hansbrough explained that UNIMED is under a yearly contract, which means that the Board of Directors of the Southeast Missouri Heart Care Foundation can decide, on a yearly basis, that they no longer need the services of UNIMED. It is anticipated that they will help administer the Foundation from two to three years.

Dr. Hansbrough indicated that he was concerned about the National Association of Foundations being a threat to medical societies and private practitioners.

District #9—Dr. Cooper stated that the societies of his district have been concerned about legislation that has been passed and some that is about to be passed. Attendance at the medical meetings is growing and he plans to meet with all of his societies in the near future.

District #8—Dr. McAlhany stated that he had no formal report for the Council.

District #4—Dr. Hetlage reported that a great deal of discussion on PSRO was held during his district conference. The general feeling was that education is very important and Dr. Hetlage hopes to have a conference in his district in early spring for educational purposes regarding PSRO. Their feeling was one of at least minimal cooperation until they see what the regulations will actually show.

Dr. Hetlage said that he had received a letter from Dr. Allen Klippel, including a status report of the Emergency Medical Services Committee. They are trying to develop an EMS Plan for Missouri with these ideas: seat belt law; ambulance design and training of EMTs; state communication authority to control EMS radio frequencies; categorization of hospitals in those areas of two or more institutions; and map a system of transport and referrals.

Discussion followed regarding the development of this EMS Plan and some of the items to be included in it. The Council Chairman indicated that in order to clarify some of these points, he would extend an invitation to Dr. Klippel to attend the next Council meeting.

Dr. Hetlage stated that rural ambulance service is in a state of turmoil at present. However, the legislation has made people realize that something must be done and some areas are voting for ambulance districts.

Dr. Hetlage indicated that a reply had been received from the Missouri Association of Osteopathic Physicians and Surgeons regarding its policy concerning its members attending medical society meetings. He read portions of the letter from the Osteopathic Association indicating that its members are not discouraged from attending medical society meetings for educational purposes. Dr. Hetlage recommended that we should encourage osteopathic participation in the scientific portions of the meetings, but not solicit them as members.

He said the Blue Shield Open Panel Program, as modified, has been accepted by both St. Louis County Medical Society and the St. Charles-Lincoln County Medical Society.

Dr. Hetlage stated that he felt that areas of medical care in the state that need investigation should be brought to the attention of the Council and appropriate action taken. He stated his concern over the deplorable conditions that exist in some of the nursing homes in the state and feels this is one of the major problems.

The Chairman indicated that there is a state agency responsible for nursing homes. Anytime a physician sees these conditions in a nursing home, he should report it to that agency.

Dr. Allen stated that the state law regarding nursing homes indicates that homes do come under it if they have three or more people for whom they are providing care. Sometimes, it is difficult to define whether or not care is being provided. The local prosecuting attorneys in some instances do take action against some of these homes.

Dr. Matthews said that he felt some type of day care system might work if the individuals had relatives who could look after them at night.

Dr. Hetlage further reported that he felt that there should be some way to keep the general public informed regarding what their benefits are under Medicare, particularly in regard to extended care facilities, and that, possibly, some pressure might be put on Congress. He suggested that this might be referred to the Commission on Medical Economics. However, the Chairman stated it might be well for the Division of Health to give us an up-to-date report on this.

District #2—Dr. Bach stated that they have been inviting D.O.s to their meetings for some time, it is working out nicely and no pressure is being put on them to join the society.

Dr. Bach said they had the president of UNIMED talking with them and UNIMED was given instructions to proceed with the organizational phase of a local foundation.

Negotiations are now going on with the local Junior College regarding training laboratory technicians for an appropriate degree. This is on a regular tuition basis.

Dr. Bach reported that one of the hospitals is presently trying to set up a pediatric intensive care unit and he would report more on this at a later date.

District #7—Dr. Chandler reported that Dr. Fred Fowler has recently taken over the duties as President of Jackson County Medical Society. Dr. Warren Wilhelm is President-Elect.

The Jackson County Medical Society building is going to be completely refurbished.

Jackson County held an educational meeting on PSRO and had a very good turnout of approximately 300 members. Three groups, including UNIMED, are now under consideration to handle the organizational problems in Jackson County. No decision has been made as to which one will be used.

Dr. Chandler stated that they have had some trouble with MARC (Mid-American Rescue Commission) in that their board had no medical representation, but only in an advisory capacity. At the insistence of Jackson County Medical Society, they now have some representation on the Board. Dr. Chandler said that sometimes in dealing with these agencies, it is necessary to take a firm stand.

The Chairman indicated that Dr. John Martin of St. Joseph was hospitalized and could not be present at the meeting.

District #6—Dr. Bradshaw had no formal report for the Council.

REPORT OF THE PRESIDENT

Dr. Stricker reported that he had participated in a 30-minute television program recently in Springfield regarding the Dr. Finch licensure situation.

The President stated that he had attended the AMA Clinical Session in Anaheim. During the AMA's full day program on PSROs, the presidents of state medical associations had a special program. They also had an extensive panel on HMOs.

Dr. Stricker attended the Grand River Medical Society Christmas Party on December 13 and said that it was a very nice affair.

REPORT OF COMMISSION ON MEDICAL-LEGAL AFFAIRS

The Commission on Medical-Legal Affairs met on November 3. Dr. Irving Clark presented four proposals by various brokers for a group professional liability insurance program for MSMA. After his summarization of the plans, the physicians present adopted the following motion:

> It is recommended that an attorney specializing in insurance be obtained to evaluate the Missouri malpractice situation, to determine a solution and to conduct a feasibility study of a group professional liability insurance program for MSMA.

On motion of Dr. Hansbrough, duly seconded, the report of the Commission on Medical-Legal Affairs was accepted and the Commission to move as rapidly as possible on this.

REPORT OF COMMITTEE ON CONSTITUTION AND BYLAWS

The Committee on Constitution and Bylaws held a telephone conference call on December 11 with all members participating. The first item for discussion concerned Resolution #13. At the 1973 Annual Session, the MSMA House of Delegates adopted the report of the Reference Committee on Constitution and Bylaws concerning Resolution #13. It was pointed out that because the Speaker and Vice-Speaker are not elected at the same time as other Delegates, it would be possible to have either the Speaker or the Vice-Speaker not elected as delegates with the result that the House of Delegates would be without these officers. The Reference Committee recommended that the Constitution be changed to provide that the Speaker and Vice-Speaker shall serve as delegates-at-large.

> The Committee recommends that Article IV of the Constitution be amended by inserting a comma following the word "Association" and adding the following words "the Speaker and Vice-Speaker." This sentence would then read, "The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker, who will serve as delegates-at-large."

The Committee also suggests that if the change in the Constitution is adopted, a corresponding change be made in the Bylaws. Chapter III, Section 2 of the Bylaws should be amended by inserting a comma and the following words "the Speaker and Vice-Speaker" following the word "Association" in the last sentence. The sentence would then read, "All Past-Presidents of the Association, the Speaker and Vice-Speaker shall serve as delegates-at-large."

Again, it is emphasized that this change is recommended because it is conceivable that the Speaker or Vice-Speaker of forthcoming Annual Sessions would not be elected as a delegate by his component society and the MSMA Constitution stipulates that the Speaker and Vice-Speaker must be elected from the body of the House of Delegates.

Dr. Whitener noted to the Committee that held over until the 1974 Annual Session is the constitutional amendment recommended by the Committee on Constitution and Bylaws and adopted by the House of Delegates at the 1973 Annual Session. This proposed amendment to the Constitution will be voted on at the 116th Annual Session in April, 1974. The amendment reads as follows:

> "Petition signed by 10% of the active members of the Association, including petitioners representing at least one half of the component Medical Societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question."

On motion of Dr. Franklin, duly seconded, the report of the Committee on Constitution and Bylaws was accepted by the Council.

REPORT OF THE COMMISSION ON CONTINUING EDUCATION AND HEALTH MANPOWER

The Commission on Continuing Education and Health Manpower, George H. Ladyman, M.D., Chairman, met on November 11.

The Ad Hoc Committee on 116th Annual Session presented a progress report indicating that specialty organizations are sponsoring a total of twenty-five 90-minute sessions. The opening session on Friday, April 5, will feature PSRO. The anesthesiologists and the surgeons are planning to cosponsor a program on emergency medical services.

Dr. Worley, Chairman of the Ad Hoc Committee on Health Manpower, reported that they received requests of the professional state nursing organization for guidelines relating to emergency lifesaving services which are sometimes required of a nurse when the physician is not present. Following extensive negotiations with the registered nurses, including advice from the related medical and surgical specialties, the Ad Hoc Committee recommends as follows:

I. *Intracardiac Drugs*

A. In those areas of special intensive care units and cardiac care units, where Registered Professional Nurses have had special educational and clinical preparation and possess the necessary skills, and the physician not being available, the nurse, if so designated, may inject medication into the heart, where cardiac standstill is recorded per monitor.

B. Registered Professional Nurses who do not have special preparation as above may not administer intracardiac medications.

II. *Endotracheal Intubation*

A. Registered Professional Nurses do not do endotracheal intubation in medical centers or hospitals where other persons such as physicians and anesthesthesiologists are available within a short period of time.

B. In areas of the state where a physician would not be available and a Registered Professional Nurse is designated as the skilled person in the institution to perform endotracheal intubation, that the nurse be trained by an anesthesiologist or a certified nurse anesthetist; and that the nurse so designated be required to practice this technique once a week or sufficiently frequently to maintain competence in this procedure.

During the Commission meeting, it was moved, seconded and voted unanimously to approve both guidelines as written.

Discussion followed regarding the report of the Ad Hoc Committee on Health Manpower. It was suggested that the first phrase in I. Intracardiac Drugs A. be removed. This paragraph would then read as follows: "A. Where Registered Professional Nurses have had special educational and clinical preparation and possess the necessary skills, and the physician not being available, the nurse, if so designated may inject medication into the heart, where cardiac standstill is recorded per monitor."

The motion was made, seconded and approved that these guidelines be accepted as amended, omitting the first phrase, "In those areas of special intensive care units and cardiac care units," and that copies of these guidelines be sent to the Missouri Hospital Association, the Osteopathic Association and the various nursing organizations.

REPORT OF AMA DELEGATES

Dr. Stanley Peterson reported on the highlights of the AMA Clinical Session held in Anaheim, Calif., on December 1-5. He indicated that both the December 10 issue of *American Medical News* and *AMA Newsletter* contain a good rundown on the various items discussed and acted upon at the AMA Meeting. Many of these actions also will appear in the News Insert of the January issue of Missouri Medicine.

Dr. Peterson indicated that Mr. Nathan Stark, Vice-President of Hallmark, will receive the AMA's Layman's Citation for Distinguished Service at the June AMA Annual Session. Dr. Peterson stated that he felt MSMA should take steps to recognize this gentleman during our 1974 Annual Session in Kansas City and, certainly, see to it that he is taken care of at the June AMA Meeting.

All Delegates and Alternate Delegates were present at the meeting, in addition to the President and President-Elect. Missouri had a good hospitality room.

Dr. Peterson stated that he felt that Missouri has arrived at a point at AMA meetings where people know we are there and we are receiving recognition accordingly.

Dr. Vernon Wilson is on the Council on Medical Education of AMA. Dr. Joseph White, new Provost for Health Affairs at the University of Missouri-Columbia, also is on this Council on Medical Education and up for reelection this year. He was elected to that Council from the state of Texas. It was Dr. Peterson's feeling that we should support Dr. White for reelection to the Council on Medical Education.

Much discussion centered around PSRO at the AMA Clinical Session. The House of Delegates approved a PSRO policy, pointing out that the best interests of the American people would be served by repeal of the legislation. The policy also continues support of AMA activities to provide constructive amendments to the law and the AMA efforts to develop appropriate regulations for PSROs. It calls upon the House of Delegates, as individual physicians and through the Board of Trustees, to inform the public and legislators of the "potential deleterious effects of this law on the quality, confidentiality and cost of medical care."

REPORT EE-PSRO

Dr. Chandler stated that we had been contacted by AMA and had been asked what our position on PSRO is and whether or not we would work for repeal. Dr. McAlhany stated that he doubted that we could suggest to Congress that a law be repealed which has not been tried. He indicated that, perhaps, we should study the law and make certain recommendations in regard to amending it. Dr. McAlhany mentioned several sections in PL 92-603 that MSMA could work toward having changed.

Dr. Bradshaw stated that he objected to the nonparticipation parts in Report EE—Paragraph 3, Page 2 and Paragraph D, Page 3, which read as follows:

> "(3) Non-participation can be interpreted in several ways. Nonparticipation by constituent and component medical societies refers to the unwillingness of such societies to cooperate in the development of PSROs. Nonparticipation by individual physicians implies unwillingness to provide professional reimbursable services for Medicare and Medicaid beneficiaries. In general, non-participation by organized medicine in the development of PSROs would be an abrogation by the profession of its responsibility to the public and the

profession to assure that monitoring of the quality and cost of medical care is professionally oriented. Regardless of participation or nonparticipation by physicians or medical organizations, no physician can escape review of his Medicare and Medicaid services as long as the law remains in force."

"(D) To suggest nonparticipation by all constituent and component societies. Such nonparticipation would specifically refer to the establishment of a PSRO by a unit of organized medicine."

Dr. Bradshaw stated that we have to be law abiding citizens, but we can work for repeal. Dr. Bradshaw moved that Paragraph 3, Page 2 and Paragraph D, Page 3 be omitted and the Council then favor the report of the Board of Trustees and the Council on Medical Service with those omissions. A motion was seconded by Dr. Hansbrough and adopted.

Dr. Peterson stated that nonparticipation is a possibility under the law. It was pointed out that the question the AMA had asked was about our position concerning repeal of the PSRO law and whether or not we would be willing to work for repeal.

A motion was made by Dr. Bradshaw that the Council believes that the PSRO Law should be repealed or effectively amended and we will work actively with the Missouri Congressional Delegation to this end. The motion was seconded followed by discussion.

Dr. Matthews stated that there isn't much chance for repeal. We should direct ourselves to amending or modifying the law to conform to something we could live with. After discussion, the vote was to approve Dr. Bradshaw's motion.

REPORT OF AD HOC COMMITTEE ON CME

Dr. Paul Young stated that the Council had an outline of the proposed Continuing Medical Education program for MSMA. The Committee has developed an educational plan for the membership which is voluntary in nature and which should achieve certain objectives which are outlined in the proposal. He indicated that a proposed budget was attached to the report.

Dr. Young stated that there is a variety of things going on in other states in regard to CME. He indicated that the committee developed an educational program which is voluntary and which could respond to local needs. The State Medical Association would provide the personnel and expenses to carry this out. Dr. Young reported that the standards for this program were being developed by each specialty on our Interspecialty Commission.

Dr. Bradshaw stated that the report was excellent, but he wondered if the committee had considered adding lay people in health related fields to this program. Dr. Young stated that the committee had discussed this, but it was not included in the proposal. He indicated that the committee would pursue this matter if the Council wishes.

A motion was made to accept the report with commendation. The motion was seconded and carried.

Dr. Bradshaw moved that the scope of the committee be enlarged to include lay education in health matters. The motion was seconded by Dr. Hetlage and carried.

REPORT OF THE PLANNING COMMITTEE

Dr. Cope reported that the Planning Committee recommends that the MSMF assessment be continued for another three years and it also recommends that the interest structure for loans be changed as follows: 2% interest rate to day of graduation from medical school; 5% interest rate for the next two years; 8% interest rate thereafter. It was felt that by raising interest rates, the principal would be paid back faster.

A motion was made to adopt recommendation #1. The motion seconded and carried.

The Planning Committee recommends that a policy manual be developed that would give in concise form policy statements that MSMA has on various issues.

A motion was made by Dr. Hetlage to accept this recommendation. The motion was seconded and carried.

Dr. Cope stated that the Planning Committee feels that some type of recognition should be developed for our members who serve on Committees, Commissions, as Councilors, Officers and AMA Delegates and Alternate Delegates.

A motion was made, seconded and carried to accept this recommendation.

A question was asked as to what type of recognition this would be. It was pointed out that this had not been worked out.

Dr. Hetlage moved that in accepting the above recommendation that this recommendation be returned to the Planning Committee for further implementation and recommendation. The motion was seconded and carried.

Dr. Cope stated that MSMA needs to make its members aware that they are members and that the Association needs to reach more members. The Planning Committee recommends that two field secretaries be hired and, also, one additional office secretary. Hopefully, these field secretaries will be able to contact every member twice a year and explain issues that are before physicians and keep the membership better informed of what is going on.

The Planning Committee also recommends that funds be made available for Councilors to use in communicating with their district members. The Committee also recommends raising MSMA dues and assessment dues to a total of $100; which would consist of $90 in dues and the $10 MSMF assessment. This dues increase would be necessary to accomplish the above recommendations as well as to provide funds for Dr. Young's continuing medical education program.

The Planning Committee recommends that the Association move into various areas of service for the membership. These services could include such things as automobile leasing, developing our own professional liability insurance company group, etc.

Dr. Cope indicated that approval was needed for the above recommendations. Dr. Hetlage pointed out that this whole report would go to the House of Delegates for its consideration and approval. Dr. Cope stated that this program, including the dues increase, should go to the House as a unit. In order to carry out these recommendations and Dr. Young's CME Program, the additional funds will be necessary.

A motion was made to accept the proposed recommendations. The motion was seconded and carried.

A motion was made to accept the report in toto. The motion was seconded and carried.

The Chairman of the Council presented a resolution submitted by Falls B. Hershey, M.D., St. Louis County, and informed the Council this would be referred to the Committee on Planning for study.

LEGISLATIVE COMMITTEE REPORT

Dr. Matthews stated that there are 30 to 35 bills related to medicine already prefiled. Dr. Matthews mentioned several bills that had already been approved for drafting, introduction and full support of MSMA. These include a so-called "sick doctor bill." This proposed legislation has had good coverage in medical society journals and the state association journal had an article on it. A lab licensing bill has been prefiled. This bill would standardize laboratories throughout the state. A physical therapy bill also has been prefiled. A delegation amendment bill also has been prefiled. This bill would allow physicians to delegate tasks to trained assistants.

A motion was made, seconded and carried to approve this section of the report.

Dr. Matthews stated that a bill has been proposed and drafted by the Board of Healing Arts, but has not yet been introduced. He indicated that this was for information only.

A patient's or inmate's rights in human experimentation bill has been prefiled.

The Governor is proposing a mental retardation bill. This bill would increase clinics, try to identify high-risk patients and provide services to children born with a high risk of developing mental retardation. This would be administered by the Division of Health. Dr. Matthews stated that a copy of the bill had been sent to the pediatric and ob-gyn sections for review. Dr. Matthews stated that the committee felt that we should take no position until we get input from pediatrics and ob-gyn.

Several bills have been introduced which would repeal certain sections of the ambulance bill that was passed by the Legislature last session.

A motion was made by Dr. Hansbrough that we oppose the attempt to repeal the ambulance bill. The motion was seconded and carried.

A bill for the licensing and practice of acupuncture is being proposed. Dr. Matthews stated that the MSMA had taken the following position in regard to acupuncture:

> "*Resolved*, that the Missouri State Medical Association urge the Missouri State Board of Registration for the Healing Arts to utilize such legal and statutory powers as may be available to declare that the principles apparently involved in the practice of acupuncture and shiatsu are medical principles and that acupuncture and shiatsu, if found to be scientifically valid and medically beneficial, would fall under the definition of the practice of medicine."

Dr. Matthews stated that, perhaps, the Council also would like to adopt the Wisconsin statement on acupuncture which is as follows:

> "The use of acupuncture to relieve pain and provide anesthesia for patients is an experimental medical procedure. Its use must be limited to licensed physicians and surgeons. It is strongly recommended appropriate training and technical expertise be acquired by the physician before attempting its use.
>
> The physician must utilize his professional training and experience in determining the use of acupuncture for a patient only after a complete medical workup and the establishment of differential diagnosis of the patient's complaint.
>
> It is recommended that the patient further understand that acupuncture is an experimental procedure at the present time, and that no guarantee can be or is made as to the success of this form of therapy, and that alternate forms of therapy, and the likelihood of their success in the treatment of their condition should be explained to them."

Dr. Franklin moved that we add the Wisconsin acupuncture statement to ours. The motion was seconded and carried.

A motion was made to adopt the above portions of the Legislative Report. The motion was seconded and carried.

Several insurance bills are in the Legislature. One calls for insurance coverage for newborns. This would increase premiums approximately $3 to $6 per year per family unit.

A motion was made by Dr. Franklin, seconded and carried to accept this.

There is a bill calling for mental health coverage in insurance policies. This would increase premiums $25 to $40 per family per year. This bill has strong support from the Missouri Psychiatric Association. Dr. Franklin moved that we favor this. The motion was seconded by Dr. Gunn and carried.

A bill calling for dental coverage in insurance policies is proposed. This bill would provide for payment of oral surgery. No action was taken.

There also is a bill calling for elimination of coordination of insurance benefits. Dr. Hetlage moved that we favor a bill for repeal of coordination of benefits. The motion was seconded by Dr. Hansbrough. The motion was not adopted.

A psychologist's licensing bill has been prefiled. Dr. Matthews stated that the psychiatric association was looking this bill over. A motion was made, seconded and carried that we support this bill if the psychiatrists approve it.

Several other bills that have been prefiled include a pharmacists bill, a bad physical therapy bill and several fireworks bills. A bill providing for education of medical students is proposed. The state would give $100,000 to 20 medical students to help finance their education. Dr. Matthews stated that the committee had taken no position on this.

A glue-sniffing bill and a bill providing for immunity from liability for peer review chiropractors have been filed.

An abortion-right to life amendment has been filed. The committee felt that we should stay with our stand on abortion.

There is a section in the state reorganization bill that calls for Missouri University to take over the Missouri Institute of Psychiatry and, also, a section regarding the licensing board. A motion was made to accept this portion of the report. The motion was seconded and carried.

MSMA-SPONSORED TOURS

Mr. Cooper reported that our Rhine Escape was held in October and it was very successful. Dr. Matthews stated that the scientific presentations during the trip were outstanding.

Mr. Cooper indicated that we had previously approved two trips for 1974: a 15-day European trip with INTRAV in June and 8-9 day Grecian trip with Marriott in August. Marriott has been selected as the AMA official travel agency. Mr. Cooper asked that another trip be considered for 1974. The proposed trip would be an 8-day trip with Marriott to Barbados in November.

A motion was made, seconded and carried to accept this proposal.

REMARKS OF THE SPEAKER OF THE MSMA HOUSE OF DELEGATES

Dr. Slickman asked that the Councilors remind their component medical societies to please get their resolutions for the handbook in to the MSMA office by February 10 or by the latest, February 18. With the new bylaws change adopted at the last session of the House, resolutions that are not in the handbook must be made available to the House of Delegates 24 hours before the session in which they are to be introduced.

Dr. Slickman also indicated that he would appreciate it if the Councilors would ask the chairman of each of their county medical society delegations to send in names of suggested delegates to serve on reference committees to either him or Mr. McIntyre as soon as possible.

Dr. Slickman stated that he would ask each county medical society delegation at the Annual Session to appoint a person to poll the delegates in their delegation in order to make voting during House sessions proceed more quickly and accurately.

REPORT OF DEANS

Dr. Mayer reported that M.U. was in the middle of admission season. The number and quality of the applicants is increasing and about one-half of the freshman class has been accepted.

Dr. Mayer stated that he would like to speak about the Missouri Institute of Psychiatry. Missouri University was asked to assume responsibility for the Missouri Institute of Psychiatry. He stated that there was a report that this would be done under the new state reorganization plan.

Dr. Mayer stated that he had just returned from the Executive Council meeting of the Association of Medical Colleges. Several pieces of medical legislation will expire on June 30, 1974. He indicated that there might be a piece of legislation that would require medical schools to charge tuition at a rate that it costs them to educate medical students.

Dr. Noback reported that the Canadian Government had issued a physician distribution report. It contained fairly realistic data.

Dr. Noback reported that they would again have students in family practice preceptorships. The quarterly proficiency examination is working well. The test covers a wide range of information. Parts of the examination have been of interest to different groups of medicine as a self-assessment tool.

Dr. Noback reported that qualifications, both personal and academic, of applicants for medical school are increasing. Construction of the Truman Medical Center, which is the replacement for General Hospital, began in October. The construction project is totally funded and should be completed in about 28½ months. The Medical School Building is nearing completion and it is hoped that it will be finished by May 15, 1974.

The Area Health Education Center program is developing. The allied health component has brought in staff and has an educational program. Pharmacists had students in preceptorships.

Dr. Noback stated that the medical school invited the Liaison Committee on Medical Education to visit the school again. He indicated that he thought it wise to have the group back sooner than needed, so that they could be brought up to date on the programs at the school. Additional faculty members have been added at the medical school.

Preliminary discussion has been held with the Johnson Foundation for support to extend the care outreach of the docent teams at General Hospital. They would like the teams to extend outside the hospital hill area.

MMPAC WORKSHOP AND LEADERSHIP CONFERENCE

Mr. Swarens reported that the MMPAC Workshop has been scheduled for Saturday, Feb. 2, 1974. This will be a work session. The AMA Leadership Conference will be held on February 23 and 24, at Ramada Inn in Jefferson City. The program deals with society leadership, public speaking, etc. and is limited to 40 people. A Practice Managament Workshop for residents will be held on May 6 and 7.

The Chairman mentioned that Dr. Bradshaw had recently been elected Chairman of the State Board of Health.

Dr. Hetlage asked if it would be possible, if a dinner or breakfast meeting could be held during the MMPAC Workshop at which people at the Workshop could meet with the Council and have a roundhouse discussion. They would be able to ask questions about various matters.

A motion was made by Dr. Bradshaw to have such a luncheon meeting. The motion was seconded by Dr. Hetlage and carried.

NEXT COUNCIL MEETING

The next Council meeting will be held on Friday, Feb. 1, 1974 at the Ramada Inn in Jefferson City. The Council will hold an executive dinner meeting on Thursday evening, January 31.

The meeting was adjourned at 4:30 PM.

Give now...

to your

medical student

loan fund.

Help deserving

young Missourians!

MISSOURI STATE MEDICAL FOUNDATION
113 Madison St., Jefferson City, Missouri 65101
SPONSORED BY THE MISSOURI STATE MEDICAL ASSN.

FINANCIAL STATEMENT FOR THE YEAR 1973

LENNERTSON & COMPANY
Certified Public Accountants
ST. LOUIS, MISSOURI 63144

January 30, 1974

Missouri State Medical Association
113 Madison
Jefferson City, Missouri 65101

Gentlemen:

A review was made of the accounts of the Missouri State Medical Association, a non-profit Missouri corporation, for the year 1973, and a report thereon is presented together with the following exhibits:

Exhibit A	Balance Sheet
Exhibit B	Income Statement
Exhibit C-1	Statement of Commissions and Meeting Expenses
Exhibit C-2	Statement of Investments
Exhibit D	Dues Receivable and Memberships by Societies.

It should be noted that members' dues and investment income are taken into income on the cash receipt basis whereas the other accounts are maintained on the accrual basis. Rentals received in advance for Annual Session exhibit space and advance contributions are shown as prepaid and carried forward to the year to which they apply.

Scope of Examination

The Balance Sheet at December 31, 1973 and the Income Statement for the year then ended were reviewed. Examinations or tests were made of the accounting records, in the manner and to the extent deemed appropriate, without making a detailed audit of the transaction.

Recorded cash receipts for the year were traced in total into the bank as deposits and disbursements for the period were substantiated by an inspection of paid checks, purchase invoices and other data on file.

Selective tests were made of the income and expense accounts for the period. It was noted that space in the Journal was contributed to the United States Treasury Department for bond advertising, to members for small classified ads, and to public service organizations.

Income Statement

The financial result of activities of the Association for the year 1973 was an excess of income over expenses of $24,397.27 as set forth in Exhibit B.

Balance Sheet

The financial position of the Association at December 31, 1973 is presented in Exhibit A. Comments on the larger balance sheet accounts follow:

Cash in banks, as shown by the books, was reconciled to the regular monthly bank statements and confirmations received from the depositories. The petty cash fund was verified by physical count.

Permanent investments with a cost of $83,618.04 were confirmed by a statement from the custodian, Mercantile Trust Co. Investment income for the year was as follows:

Interest—Certificate of Deposit	$ 9,371.53
Interest and discount on bonds	2,809.31
Dividends on Stock	3,240.24
Total Investment Income	$15,421.08

Accounts Receivable-Advertisers of $3,967.41 represent the unpaid balance due from Journal advertisers. Of this amount $3,762.41 was due from the State Journal Advertising Bureau as follows:

December 1973	$1,510.75
November 1973	2,161.56
Prior to November 1973	90.10
Total	$3,762.41

In January, 1974, a check was received paying $2,251.66 of the November and prior accounts.

Unpaid dues of $5,075.00, offset by a reserve account in like amount, represent 1973 dues of delinquent members carried at the request of local Societies. Other delinquent members were dropped from membership in accordance with the by-laws. Exhibit D presents a summary of unpaid dues and membership by Societies, as shown by the records of the Association.

The Association completed the renovation of the building purchased in 1972 and moved into their new offices in May, 1973. The building with a cost of $116,431.52 will be depreciated over a useful life of 30 years and the furniture and fixtures in the amount of $20,669.04 has a 10 year useful life. Yearly depreciation will not be included as an expense, but depreciation less principal mortgage payments, will be recorded as a reduction to "Reserve for Future Activities."

Purchases of small equipment, rentals and repairs for the year in the sum of $3,496.59 were charged to expense in lieu of depreciation.

The records were carefully reviewed for liabilities at December 31, 1973 and it is believed that all current liabilities of substantial amount are included in the Balance Sheet.

Exhibitors have made advance payments of $3,045.00 for annual session exhibit space and these payments will be taken into income when earned in 1974.

A real estate mortgage was obtained on December 1, 1973 in the amount of $72,000 from Mercantile Mortgage Co. The mortgage is for a term of 15 years at 7% interest with monthly payments of $647.16 including interest. Two payments were made in 1973 resulting in a loan balance at December 31, 1973 of $71,544.35.

The excess of assets over liabilities in the amount of $215,494.64 is shown in the Balance Sheet as a "Reserve for Future Activities."

General

During the year, payments were made to and for the following sponsored organization:

Missouri State Medical Association Pension Fund—	
Employees' Retirement Insurance Pension	$ 7,679.87
Employees' Pension Plan Contribution	5,520.60
Total	$13,200.47

The association continues to provide indirect financial assistance to the Missouri State Medical Foundation (Medical Student Loan Fund).

Collections for the American Medical Association and the Missouri State Medical Foundation are made along with the Missouri State Medical Association annual dues. Following is a schedule of dues and assessments for each member in effect during the year 1973.

	Active	*Junior*
Journal	$ 3.00	$ 3.00
Association General Fund	62.00	7.00
Foundation Assessment	10.00	—
Missouri State Medical Association—		
Dues and Assessments	$ 75.00	$10.00
American Medical Association	110.00	20.00
Totals	$185.00	$30.00

Except for $5.00, the 1973 collections of $39,087.50 for the Missouri State Medical Foundation have been remitted along with $182.50 due from the year 1972. The $110 per Active member and $20 per Junior member collected for the A.M.A. totalling $349,340.00 has been remitted.

Insurance policies were inspected and the following general insurance was in force at the close of the year:

Insurance on	*Type of Coverage*	*Amount*
Building	Fire and Extended Coverage (90% co-ins)	$110,000
Land and Building	Title Insurance	$125,000
Liability	Bodily Injury and Property Damage Liability	$300,000/300,000
Liability	Premise Medical Payment	$500/10,000
Furniture and Fixtures	Fire and Extended Coverage	$15,000
Employees	Workmen's Compensation	Statutory
President, Executive Secty., Office Manager, Bookkeeper Stenographer	Fidelity Bond	$10,000
Treasurer	Fidelity Bond	$20,000
Journal Publication	Publisher's Liability ($2,500 deductible)	$500,000
Journal Publication	Advertisers' Libel ($2,500 deductible)	$500,000
Automobiles of Three Assistant Secretaries	Non-ownership—Bodily Injury	$100,000/300,000
	Non-ownership—Property Damage	$25,000
Executive Secretary Leased Auto	Non-ownership—Bodily Injury	$100,000/300,000
	Non-ownership—Property Damage	$50,000
	Non-ownership—Collision	$100 Deductible
Members and Auxiliary Members on M.S.M.A. business under age 70	Travel Accident (away from home)	$25,000/250,000 $500 Medical Expense

Subject to the comments thereon, the attached statements, in our opinion fairly present the financial position of the Missouri State Medical Association at December 31, 1973, and the result of the activities for the year then ended. The records for the year were kept in accordance with accepted principles of accounting applied on a basis consistent with that of the preceding year.

Yours very truly,
Lennertson & Co.
Certified Public Accountants

Exhibit A

Missouri State Medical Association Balance Sheet, December 31, 1973

Assets

Cash		
Mercantile Trust Co. (Treasurer's Account)	$ 10,558.27	
Central Missouri Trust Co. (Secretary's Account)	83.59	
Petty Cash Fund	25.00	
Certificate of Deposit	40,000.00	$ 50,666.86

Investments at Cost (Exhibit C-2)		
Corporate Bonds	$ 5,000.00	
Corporation Stocks	78,618.04	
Total (Market Value $91,284.50)		$ 83,618.04
Accounts Receivable		
Advertisers	$ 3,967.41	
Others	171.10	$ 4,138.51
Dues Receivable—Exhibit D (See Reserve-Contra)		$ 5,075.00
Fixed Assets (At cost)		
Pledge on Mortgage Payable		
Land	$ 26,000.00	
Building	116,431.52	
Furniture and Fixtures	20,669.04	
Total	$163,100.56	
Less Reserve for Depreciation	3,965.31	$159,135.25
Advance for Travel Expense		$ 319.99
		$302,953.65

Liabilities

Accounts Payable		
Supplies and Expenses	$ 7,274.97	
Payroll Taxes	239.69	
Due Missouri State Medical Foundation	5.00	$ 7,519.66
Deferred Credit to Income		
Advance Payment by Exhibitors for 1974 meeting	$ 3,045.00	
Advance Contribution—Annual Meeting	275.00	$ 3,320.00
Reserve for Uncollected Dues		$ 5,075.00
Real Estate Mortgage (payable $647.16 per month including interest)		$ 71,544.35
Reserve for Future Activities		
Balance 1/1/73	$196,993.45	
Depreciation less principal mortgage payment	(3,509.66)	
Loss on Sale of Investments	(2,386.42)	
Excess of Income over Expense—Exhibit B	24,397.27	$215,494.64
		$302,953.65

Exhibit B

Missouri State Medical Association
Income Statement, for the Year 1973

Particulars	*General Activities*	*Journal Publication*	*Total*
Dues Received (including $3.00 per member annually for the Journal)	$242,962.92	$12,000.00	$254,962.92
Rentals—Annual Session Exhibit Space	8,750.00		8,750.00
Annual Session Contributions	1,350.00		1,350.00
Subscriptions to the Journal—Nonmembers		916.40	916.40
Advertising Space—The Journal		33,686.88	33,686.88
Investments—Interest and Dividends	15,421.08		15,421.08
Collection Fees on A.M.A. Dues	3,911.20		3,911.20
Tour Reimbursement	4,406.74		4,406.74
Reimbursed Fee for Services	291.46		291.46
Total Income	$277,093.40	$46,603.28	$323,696.68
Expenses			
Salaries	$111,126.05	$16,721.45	$127,847.50
The Journal—Paper, Printing, etc.		38,211.99	38,211.99
Cash Discount to Advertisers		306.91	306.91
Commission on Journal Advertising		4,206.58	4,206.58
Auto Expense	2,331.56		2,331.56
Commission and Meeting Expense	55,554.46		55,554.46
Custodian Fees—Investments	549.56		549.56
Dues and Subscriptions	612.00		612.00
Employees' Pension Plan Contribution	11,477.82	1,722.65	13,200.47
Equipment Purchases, Rentals and Repairs in lieu of Depreciation	2,991.48	505.11	3,496.59
Insurance—General	1,788.75		1,788.75
Insurance—Blue Cross	1,853.88	341.49	2,195.37
Interest Expense	5,214.60		5,214.60
Mortgage Principal Payments	455.65		455.65
Occupancy Expense	4,153.29	836.85	4,990.14
Postage	5,318.75		5,318.75
Professional Fees	6,588.80	750.00	7,338.80
Stationery, Printing and Office Supplies	4,186.27		4,186.27
Student Awards	225.00		225.00
Taxes—Payroll	4,615.99	891.13	5,507.12
Taxes—Other	2,116.39		2,116.39
Taxes—Real Estate	113.86		113.86
Telephone and Telegraph	6,316.61	1,128.41	7,445.02
Traveling Expenses—Executive Secretary and Assistants	6,086.07		6,086.07
Total Expenses	$233,676.84	$65,622.57	$299,299.41
Excess of Income or (Expenses)	$ 43,416.56	($19,019.29)	$ 24,397.27

Exhibit C-1

Missouri State Medical Association
Statement of Commissions and Meeting Expenses for the Year 1973

Annual Session		$22,583.79
Council		7,921.22
Delegates to A.M.A.		13,570.10
Public Affairs		7,455.77
Women's Auxilary		2,962.05
Commissions:		
Commission on Medical Economics, Third Party Medicine and Governmental Relations	$ 83.57	
Commission on Continuing Education & Health Manpower	727.13	
Commission on Interspecialty Medicine	59.73	
Committee on Constitution & By-laws	142.93	
Committee on Planning	38.50	
Committee on Voluntary Health	9.67	1,061.53
Total		$55,554.46

Exhibit C-2

Statement of Investments December 31, 1973

Description	*Bonds at Par*	*Cost*
Pacific Gas & Electric 4½% due 6/1/90	$5,000.00	$ 5,000.00
Johns-Mansville 400 shares		5,582.34
Central & Southwest Corp. 400 shares		6,345.62
American Home Products Corp. 150 shares		3,006.88
Firestone Tire & Rubber Co. 140 shares		3,771.93
Baker Oil Co. 165 shares		5,940.09
Interco-Common no par 332 shares		9,997.20
J. P. Morgan & Co. 244 shares		5,161.93
International Tele. & Tele. Corp. 100 shares		6,986.25
F. W. Woolworth 140 shares		5,574.38
Bankamerica Corp. 400 shares		13,751.15
Texaco, Inc. 200 shares		6,937.26
International Paper 145 shares		5,563.01
		$83,618.04

Exhibit D-1

Missouri State Medical Association
Dues Receivable and Membership by Societies
December 31, 1973

	MEMBERSHIP				
	Junior	*Active*	*Honor*	*Total*	*Unpaid Dues*
Andrew		3		3	
Audrain		20	1	21	
Barton		3	2	5	
Boone	10	169	4	183	$1,155.00
Buchanan		89	15	104	
Butler-Wayne-Ripley		51	1	52	75.00
Callaway		17		17	
Cape Girardeau	2	60	2	64	10.00
Chariton-Macon-Monroe-Randolph		16	3	19	
Clay		89	4	93	187.50
Clinton		3	1	4	
Cole	1	57	3	61	150.00
Cooper		7		7	
Dallas-Hickory-Polk-Dade		10	1	11	75.00
Dunklin		17	2	19	
Franklin-Gasconade-Warren		25		25	225.00
Grand River		38	3	41	
Greene		208	10	218	
Henry		7	1	8	
Howard		4		4	
Jackson	9	779	143	931	300.00
Jasper	1	74	5	80	225.00
Jefferson	1	22	2	25	75.00
Johnson		14	1	15	
Lafayette-Ray		23		23	75.00
Lewis-Clark-Scotland		1		1	
Marion-Ralls-Shelby		26	2	28	
Mid Missouri		27	1	28	
Miller		2		2	
Mineral Area		29	1	30	
Moniteau		3		3	
Montgomery		1	1	2	
Morgan		5		5	
North Central	1	2	2	5	
Northwest Mo.		14		14	375.00
Ozark		37	5	42	$ 150.00
Pemiscot		12		12	75.00

Perry-Ste. Genevieve		12	1	13	
Pettis		27		27	
Pike		9		9	75.00
Platte		6		6	
St. Charles-Lincoln	1	61	1	63	225.00
St. Louis City	69	1,335	132	1,536	1,612.50
St. Louis County	10	455	46	511	10.00
Saline		9		9	
Semo		31	4	35	
South Central		15	1	16	
Webster		2		2	
West Central		31	6	37	
Totals	105	3,957	407	4,469	$5,075.00 (A)

(A) Delinquent dues of members at December 31, 1973 carried at the request of local Societies.

FINANCIAL STATEMENT FOR THE YEAR 1973

LENNERTSON & COMPANY

CERTIFIED PUBLIC ACCOUNTANTS

ST. LOUIS, MISSOURI 63144

January 28, 1974

Missouri State Medical Foundation
113 Madison
Jefferson City, Missouri 65101

Gentlemen:

An examination was made of the Balance Sheet of the Missouri State Medical Foundation, a non-profit Missouri corporation, for the year 1973. The Balance Sheet at December 31, 1973 is on a cash basis and the additions and deductions for the year are set forth in Exhibit A.

Recorded receipts for the year were traced in total into the bank account as deposits and paid checks were seen for the disbursements. A direct confirmation was received from the depository in verification of the cash balances on deposit.

A summary of the loans to medical students follows:

Loans Receivable January 1, 1973	$420,383.01
Loans made during the year	78,450.00
Total	$498,833.01
Less Loan Repayments	18,660.35
Less Loans Written Off	2,500.00
Loans Receivable December 31, 1973	$477,672.66

Positive confirmations were mailed as of September 15, 1973 by the Foundation on 267 individual loans which we had received positive confirmations in 1972. On 33 new loans and 8 loans not previously confirmed we mailed positive confirmations with requests to return the confirmations direct to the auditors. Of the 308 loans, 287 were confirmed for a total of $444,663.58 out of total loans of $477,672.66. No additional loans were made after September 15, 1973.

The Foundation has set up a reserve for losses on student loans in the amount of .05% monthly on the outstanding loan balances. An addition of $2,854.98 was made for the year 1973 and two loans were charged off leaving a reserve balance of $2,754.76 at December 31, 1973. Interest income on loans is recorded on a cash basis and the amount received in 1973 was $5,988.30. Accrued interest on outstanding loans at December 31, 1973 amounted to $35,885.02 and is not included in the loan balances in Exhibit A.

Interest received on the savings account and the certificates of deposit amounted to $1,599.29. The certificates of deposit in the amount of $44,083.51 had earned $1,838.33 of interest at December 31, 1973 which will be recorded on the books when received in 1974.

The Foundation received $31,499.63 from the Dr. Richard S. Battersby Estate. This is shown on Exhibit A under contributions.

The Missouri State Medical Foundation incurred the following expenses for the year ended December 31, 1973:

State Registration Fee	$ 1.00
Professional Fees	529.90
Office Expense	2.20
Printing	169.60
Office Furniture	611.80
Addition to Reserve for Losses	2,854.98
Total	$4,169.48

U. S. Treasury Department form 990 and Schedule A will be prepared for the year 1973 and are due for filing by May 15, 1974. The Foundation is not liable for Federal Income Taxes as it is classified as a Tax Exempt Charitable Organization.

We have examined the Balance Sheet of Missouri State Medical Foundation as of December 31, 1973, prepared on the cash basis. The examination was made in accordance with generally accepted auditing standards and include such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. Since the Balance Sheet is on the cash basis, no opinion is expressed on the attached statement as accrued interest on loans of $35,885.02 and $1,838.33 of accrued interest on certificate of deposit is not shown.

Yours very truly,
LENNERTSON & CO.
Certified Public Accountants

EXHIBIT A

Missouri State Medical Foundation
Balance Sheet (Cash Basis), December 31, 1973

Assets

Cash		
Checking Account	$ 24,423.63	
Savings Account #05842586	18,123.28	
Certificate of Deposit #A83068 due 1-15-74	15,000.00	
Certificate of Deposit #A83088 due 3-8-74	10,000.00	
Certificate of Deposit #A80038 due 1-7-74	19,083.51	
Total Cash		$ 86,630.42
Loans Receivable from Medical Students	$477,672.66	
Less Reserve for Losses	(2,754.76)	474,917.90
		$561,548.32

Fund Reserve

Balance January 1, 1973		$485,108.58
Additions and Deductions for Year 1973		
Interest on Loans	$ 5,988.30	
Interest on Bank Deposits	1,599.20	
Contributions (see below)	33,756.63	
Assessment of Members, Active $10.00	39,265.00	80,609.13
Total		$565,717.71
Less Expenses for Year		(4,169.48)
		$561,548.32

Contributions

Richard S. Battersby Estate	$31,499.63
Woman's Auxiliary to Buchanan County	165.00
Woman's Auxiliary to M.S.M.A.	300.00
Woman's Auxiliary to Jackson County	150.00
Max S. Franklin, M.D.	100.00
Woman's Auxiliary to Clay County Christmas Project	238.00
Boonville Medical Group	100.00
Miller's Medical Art Pharmacy, Boonville, Mo.	100.00
Sub Total	32,652.63
Contributions under $100.00 each	1,104.00
Total Contributions	$33.756.63

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

The Cape Girardeau County Medical Society held its regular monthly meeting in the Chamber of Commerce rooms in Cape Girardeau at 8 PM on December 11. Dr. M. H. Shelby, President, called the meeting to order. Other members present were Drs. B. W. Hays and D. I. L. Seabaugh, Jackson; S. Doggett, O. L. Seabaugh, W. N. Howard, J. H. Cochran, J. J. Drace, J. F. Chostner, O. H. Hope, H. V. Ashley, W. E. Yount and C. A. W. Zimmerman, Cape Girardeau. The following officers were elected for the ensuing year: President, Dr. H. V. Ashley; Vice-President, Dr. D. I. L. Seabaugh; Secretary, Dr. C. A. W. Zimmerman; and treasurer, Dr. B. W. Hays.

The last meeting of the Clay County Medical Society for 1933 was held at the Jack-O-Lantern Cafe in Liberty on December 21. Twenty members and wives were there and partook of an excellent turkey dinner. The following officers were elected for 1934: President, Eugene C. Robichaux, Excelsior Springs; Vice-President, Dr. Harry R. Staley, North Kansas City; Secretary-Treasurer, Dr. J. J. Gaines. Excelsior Springs.

The Cass County Medical Society met in its regular quarterly session in Harrisonville on December 14 with Dr. H. A. Brierly of Peculiar presiding. The following officers were elected for 1934: President, Dr. T. W. Adair, Archie; Vice-President, Dr. William Beckman, Strassburg; and Secretary-Treasurer, Dr. J. S. Triplett, Harrisonville.

TWENTY-FIVE YEARS AGO

Representatives of the Missouri State Medical Association attended a meeting of the American Medical Association Coordinating Committee for the Protection of People's Health on February 12 in Chicago. The public relations firm of Whitaker and Baxter of California has been employed to direct the educational campaign. Special emphasis is to be placed on the development of voluntary prepayment medical care and hospitalization plans. A great part of the funds which will be secured through the assessment of $25 per member of the AMA is to be devoted to making the public aware of the official program of the American Medical Association.

The book, "Sexual Behavior in the Human Male," by Alfred C. Kinsey, Professor of Zoology at Indiana University; Wardell B. Pomeroy, Research Associate, Indiana University; and Clyde E. Martin, Research Associate, Indiana University, Philadelphia and London, was published by W. B. Saunders Company in 1948. Price was $6.50. This book is a colossal case history study of sex habits of about 12,000 American males of all ages, of all social and economic classes, of all levels of education from pre-kindergarten to college professors and of various occupational, religious and geographic districts. The information presented is extremely pertinent and is needed by physicians in caring for patients who consult them for information and advice and for psychosomatic complaints based on conflicts involving personal sex practices and maladjustments.

TEN YEARS AGO

A large audience of physicians, their wives and guests attended the 129th Annual Meeting of the St. Louis Medical Society on January 7, where they witnessed an impressive ceremony of the installation of officers for 1964. Newly-installed officers were Drs. David N. Kerr, President; Walter T. Gunn, President-Elect; R. W. Kelley, Vice-President; R. V. Bradley, Secretary; C. H. Nicolai, H. A. Ritter and E. A. Powell, Councilors.

The newly-elected officers of the St. Louis County Medical Society for 1964 were installed at the installation dinner-dance on January 8 at Le Chateau in St. Louis County. Kenneth C. Hollweg, M.D., President of the MSMA, conducted the official installing procedure. New officers included Drs. James R. Nakada, President; James C. Sisk, President-Elect; Stanley L. Harrison, Vice-President; C. Howe Eller, Secretary.

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Contraindications: Patients with known hypersensitivity to the drug.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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The patient may have difficulty in accepting medical counsel.

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This psychoneuroti often respond

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal be associated with temporary increase in frequency and/or seve of seizures. Advise against simu taneous ingestion of alcohol and other CNS depressants. Withdra symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt disco tinuance (convulsions, tremor, a dominal and muscle cramps, vom and sweating). Keep addiction-p individuals under careful surve lance because of their predispos to habituation and dependence. pregnancy, lactation or women childbearing age, weigh potentia benefit against possible hazard.

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epressive symptoms are associated
ith or secondary to predominant
nxiety in the psychoneurotic
atient, consider Valium (diazepam)
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upport it provides. As anxiety is
elieved, the depressive symptoms
eferable to it are also often relieved
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Valium® (diazepam)

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r psychotropics or anticonvul-
s, consider carefully pharma-
gy of agents employed; drugs
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r antidepressants may poten-
its action. Usual precautions
cated in patients severely de-
sed, or with latent depression,
ith suicidal tendencies. Observe
l precautions in impaired renal
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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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A Review of 1973-1974

University of Missouri-Columbia Medical Center

By

WILLIAM D. MAYER, M.D.

Dean of the School of Medicine

Annually, as I attempt to relate in the April issue of Missouri Medicine the "happenings" of the previous year at the University of Missouri-Columbia Medical Center, I am faced with a major task of choice; to choose on any rational base which of the multiple developments in our educational, patient care and research programs of the previous year are most worthy of comment is a virtual impossibility. Anything approaching a comprehensive review would probably fill this total issue of Missouri Medicine. Anything short of that, on one hand, is sure to omit issues of potential interest to some readers while, on the other hand, leave the Dean in the awkward position of having implied some preferential importance of one development over the other. In trying to avoid this dilemma, I will limit my remarks to only two issues of potential broad interest which have total Medical Center implications. These are "Administrative Changes Within the Center" and "Medical School Admissions."

Administrative Changes

As I reported in the April, 1973 issue of Missouri Medicine, two major reorganization proposals approved by the University's Board of Curators at its September, 1972 meeting had potential direct effect on the University Medical Center. The first proposal established a reorganization of the Chancellor's Office and the second, a reorganization relating to health affairs on the Columbia campus. While still in the process of implementation, changes have occurred which are of note.

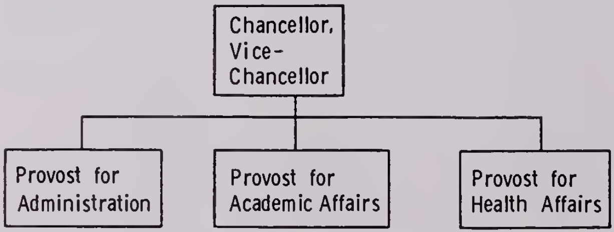
Chancellor, Vice-Chancellor
Provost for Administration
Provost for Academic Affairs
Provost for Health Affairs

Fig. 1 Reorganization of Chancellor's Office.

Reorganization of the Chancellor's Office, depicted in Fig. 1, has been completed. Dr. Walter Daniel, former President of Lincoln University, was appointed Vice-Chancellor. Dr. John F. McGowan, formerly Dean of Extension, was appointed Provost for Administration. On Aug. 1, 1973, Dr. Owen J. Koeppe, formerly Chairman of the Department of Biochemistry of the School of Medicine, was appointed Provost for Academic Affairs for the Columbia campus. On September 1, Joseph M. White, M.D., former Vice-President for Academic Affiairs and Dean of the School of Medicine at the University of Texas Medical Branch in Galveston, was appointed Provost for Health Affairs.

Dr. White, a native of Dallas, attended Southern Methodist University as an undergraduate and received his M.D. degree from the University of Texas Southwestern Medical School in Dallas. An anesthesiologist by specialty, he was chairman of that department at Oklahoma, later becoming Dean of the School of Medicine there before moving to Galveston. A member of numerous professional organizations and national committees, Dr. White serves on the AMA's Council on Medical Education. Dr. Vernon Wilson of our faculty also is on the Council. Thus, Missouri is the only state with two members in that prestigious group.

Dr. White's arrival in September enabled implementation of the reorganization of health affairs for the Columbia campus, as depicted in Fig. 2. Joe S. Greathouse has assumed responsibilities as Director of the University Hospital. Mr. Greathouse, who had been director of Vanderbilt University Hospital in Nashville for five years prior to coming to Columbia, has brought to our University the skills of one of the best known and most highly respected teaching hospital administrators in this country.

At the request of Provost White and Chancellor

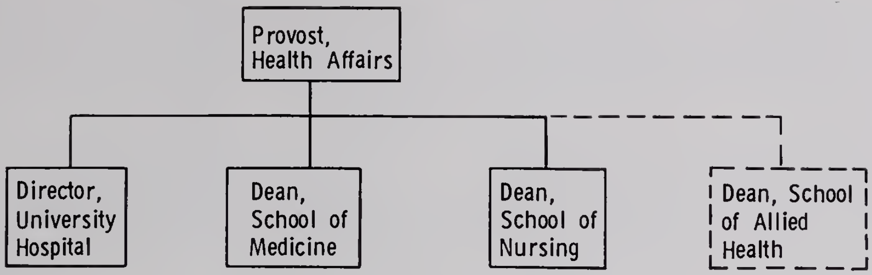

Fig. 2 Reorganization of Health Affairs.

Herbert W. Schooling, I agreed to continue to serve in my capacity as the Dean of the School of Medicine. With Dr. Ruby Potter's retirement in September, 1973, Miss Jane Brinton, former assistant to Dr. Potter, was named Interim Dean of the School of Nursing. A committee, which was appointed by Provost White and is under the chairmanship of Provost Koeppe, is conducting a nationwide search for a new Dean of Nursing. With the completion of that process, hopefully, reorganization of the existing administrative elements will have been accomplished within the next few months.

The final element of the reorganization as demonstrated in Fig. 2 is represented by the potential establishment of a School of Allied Health. With well over 400 students at the baccalaureate level now enrolled in allied health programs, Chancellor Schooling has appointed a campus-wide committee to review the possibilities of the establishment of a School of Allied Health. If such a school is developed, then a search committee for that dean will be implemented.

I feel that these reorganization efforts have been significant steps forward in the orderly growth and development of the Medical Center's programs. It indicates meaningful acknowledgement by the University administration of the importance of health activities in the overall programs of the Columbia campus and it provides a more effective way of carrying out these programs.

Medical School Admissions

By the time this article is in print, another season of medical school admissions will have been completed. By then, we may have received many letters and phone calls inquiring about the wisdom of our judgments, some even raising questions about the sanity of the Dean and the Admissions Committee. Clearly, there will always be differences of opinion when judgments are made by one group of humans about another group, for the very nature of the human endeavor and its complexities virtually assures such differences of opinion. Given the imposition of the judgmental process, however, the magnitude of the effort and energy which this School of Medicine invests in that process hopefully minimizes the error which might occur. The 17-member Admissions Committee begins its activity in August and continues its work until the class has been admitted and the alternates have been selected, which usually is about the first of April. This eight-month effort involves thousands of man- and woman-hours in reviewing applicant files and interviewing prospective applicants and in detailed Committee discussions and decision-making on each of the applicants. In addition, I personally review all of the admissions files of the accepted Missouri students, as well as those ballotted to be on the alternate list, and the majority of those who are not recommended for acceptance. I can assure you the task of the Committee is not an easy one.

The complexity of their work has been magnified several fold over the past two to three years by the truly remarkable increase in the quantity and quality of the medical school applicant pool. This increase has occurred not only in Missouri but nationwide. While it speaks well for the quality of our student body and the future of our profession, it increases the problems of the Admissions Committee significantly. Perhaps the scope of this change can be felt in part by the following personal vignette. In the three-year period, more than a decade ago between 1961 and 1964 when I served as Assistant Dean for Admissions and Student Affairs and as Chairman of the Admissions Committee, the number of Missouri applicants each year ranged from 200 to 250. This was for a class size which was initially at 75 and later at 85. The mean undergraduate grade point average (GPA) of the 75 to 85 *accepted* applicants was approximately 2.9 (A = 4.0). For our current freshman class and the class which will enter in August of this year, we had approximately 700 Missouri applicants for each class with the mean GPA of the total applicant pool of 3.2. Although the class entering in August has not been fully completed at the time of this writing, the 80 students accepted to date have an average GPA of 3.6. That is an equivalent of three A's and two Bs for every semester throughout their entire college career.

I have chosen the GPA for comparative purposes not because it is the only factor in the judgment, for this is far from the case, but because it does provide at least some quantitative feel for the magnitude of the change which is occurring. If we were to use grades alone or even in conjunction with the Medical College Admission Test scores, the entire admission process could be placed on a computer and the thousands of faculty hours of effort and the not-insignificant amount of time invested by the Dean could be put to other use. However, we feel quite strongly that there is something more to being a member of the medical profession than one's intellectual prowess in course work in college. We do attempt to assay the individual's motivations and commitments to medicine, his or her ability to relate to people on a one-to-one basis as well as in relation to groups—peers and others. We do attempt to assay the breadth of interests each applicant has, including vitality and energy levels, and try to evaluate emotional stability. We also try to seek out either demonstrated achievement or commitment to being of assistance to fellow human beings. Demonstrated evidence of general maturity as well as demonstrated leadership ability also are helpful.

It is a sobering reality to many of us when we realize that if we were applying to medical school today, we might not be accepted. It also leads to the instant, ego-protecting conclusions that clearly there must be something wrong with the admissions process if that is the case, in that each of us tends to feel that "Over the years since I have been involved in Medicine, I have made some worthwhile contributions to the profession and to the citizens I serve."

There is, hopefully, another possible conclusion: the profession tomorrow will be better and the citizens will be better served because many of those entering Medicine today are better in multiple ways than many of us who entered earlier. Whether this proves to be the case only time will tell. However, as I watch the process unfold, as I see the quality and quantity of applicants seeking admission to our profession and as I observe the size of the effort and, hopefully, *quality* of collective wisdom going into the judgment about those applicants, I am inclined to believe that there is reason to be optimistic about the future of our profession. Although I am concerned, as I am sure are many of you, relative to the increasing intervention of federal and state government and other regulatory bodies into the very nature of the practice of medicine, I am equally convinced that our profession in the future is going to be populated by a group of men and women with capabilities exceeded by none. That reality enables me to look to the future of our profession with a high degree of optimism. It also makes it easier to face the almost insurmountable problems confronting the admissions process.

In conclusion, if you have concerns about our admissions process or hear of others who do, and if these brief comments have not helped fully resolve your concern, please do not hesitate to contact me. The task with which we are faced is not any easy one, but it is an important one and we need all of the constructive assistance that we can get.

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The Disability Income Policy sponsored by the Missouri State Medical Association since 1943 has now been made GUARANTEED RENEWABLE and income benefits are available up to $300.00 weekly to members under age 56 subject to acceptance by the Company.

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WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
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MSMA NEWS ROUND-UP

APRIL, 1974

'Beginning Practice' seminar set

The MSMA and the AMA will co-sponsor a seminar on "Establishing Yourself in Medical Practice" at the St. Louis Medical Society's Building on May 6 and 7. The program is specially designed for physicians about to begin practice.

This practice-management workshop will be limited to 25 physicians. The course is subsidized by the AMA Education and Research Foundation, but there is a fee of $35 for AMA members and $60 for non-members of AMA.

Interested physicians should contact C. C. Swarens at the Missouri State Medical Association, 113 Madison Street, Jefferson City 65101, (telephone 314-636-5151).

Solo practice, partnership, professional incorporation, and group practice are all discussed, along with the factors that make each attractive and the handicaps attendant upon each one.

The location of the new practice is discussed, with consideration given to public needs, professional factors, economic factors, personal preference, and ways to supplement income during the first years.

The question of whether to buy, rent, lease, or build an office is evaluated. Legal questions are answered, costs are described, and a checklist of jobs to be done and items to be furnished in opening a new office is supplied.

Problems of state licenses, narcotics licenses, hospital privileges, public health obligations, and announcements are discussed. All facets of insurance coverage are described, including malpractice, general liability, comprehensive casualty, accident and health, disability, office overhead, umbrella, employee, fidelity bonding, and life insurance.

Attention is given to such mechanics as telephone techniques, appointment scheduling, recordkeeping, and supplying useful information to patients.

The business side of medicine includes problems such as how much to charge, explaining medical costs, keeping track of income and expenditures, elements of a good financial records system, and simple bookkeeping. These problems are explained, and solutions offered, based upon the best information available to the AMA.

(Continued on next page)

Ron Ellison will join MSMA staff

Ron Ellison

Ron Ellison of Jefferson City has been named Executive Assistant of the Missouri Medical Association.

Ron 27, originally hails from Springfield, where he was employed as a merchandise and retail manager.

In September of 1970, he joined the Missouri Hospital Association's staff in Jefferson City, first as field representative, then as director of the Missouri Health Careers Program and then promoted to administrative assistant responsible for the educational programs.

Ron attended Evangel College in Springfield and earned his B.S. Degree in Business Administration from Lincoln University in Jefferson City, where he is currently working for a Masters Degree.

His interest in young people carries over from his normal responsibilities to sponsorship of Teens Against Dystrophy Chapter, Explorer Medical Post, and is advisor on the Youth Ministry Council of the First United Methodist Church in Jefferson City.

Ron's wife, Carol, is also continuing her education in Sociology and Nursing at Lincoln University. They have one child, Jeffrey Anderson.

Thomas P. Fox retires as Executive Assistant

Thomas P. Fox, Executive Assistant of the Missouri State Medical Association, retired effective April 1 due to health reasons. He will remain with the MSMA through the 116th Annual Session.

Mr. Fox, who has been with MSMA for about 13 years, and his wife, Dorothy, plan to reside for the present at 1122 Major Drive in Jefferson City.

Among the many Association activities Tom has handled the past several years are the posts of Convention Manager for the Annual Sessions of the MSMA and Assistant Secretary of the Missouri State Medical Foundation student loan program.

Tom has also been staff representative to the Commission on Interspecialty Medicine, Commission on Continuing Education and Health Manpower and countless special committees. He also represented the MSMA in liaison with hospital, nursing and osteopathic organizations and many of the state health-related divisions.

Rep. Richard Ichord (left) talks with Dr. and Mrs. B. J. Bass of Salem at the AMA/AMPAC Public Affairs Workshop in Washington, D.C. (H. Smith Photo)

MMPAC captures national award

The Missouri Medical Political Action Committee (MMPAC) was recently awarded the first place plaque in the All-Events category of the 1973 AMPAC Membership Competition.

The competition was judged on a basis of six categories with points given for placing in each category. MMPAC placed third in the Contribution Per Member category and second in the Sustaining Membership category.

John N. Martin, M.D., St. Joseph, Chairman of MMPAC, and Hubert A. Ritter, M.D., St. Louis, MMPAC Secretary, were among about 30 Missourians attending the AMA/AMPAC Public Affairs Workshop in Washington, D.C., where the award was presented.

A new informational pamphlet on MMPAC has been prepared for distribution. Requests for the pamphlet should be mailed to MMPAC, P. O. Box 755, Jefferson City, Missouri 65101.

'Beginning Practice'

(Continued from Page 1)

Another area of concern to physicians beginning medical practice is that of personnel management — hiring, training, compensating, and supervising the office assistants who are so necessary to efficient delivery of medical care. Job descriptions are suggested, along with hints on pay and incentives, vacation and sick leave policies that can avoid misunderstanding and difficulty between the doctor and his employees.

Finally, the workshop includes a session on personal relations, from the appearance and warmth of the office, through the activities of the office assistants, to the doctor's own responsibilities to his patients.

The workshop on "Establishing Yourself in Medical Practice" serves an important purpose in completing a doctor's education. It will be especially useful to those doctors entering practice in 1974 and 1975.

** News-in-Brief **

Physicians recognized

A total of 136 Missouri physicians have qualified for the 1972 AMA Physician's Recognition Award.

The 1972 Award was granted for a minimum total of 150 credit hours of continuing medical education activities that were earned for the three-year qualifying period of July 1, 1969, to June 30, 1972. Of the 150 credit hours, 60 must have been in Category 1.

A list of the physicians receiving the Award is being sent to Presidents of County Medical Societies.

A booklet explaining the AMA Physician's Recognition Award is available by writing MSMA Headquarters, Box 1028, Jefferson City, Missouri 65101.

Mrs. Wildeboor honored

Mrs. Mary Lou Wildeboor Lederer of Warrensburg has been named 1974 Missouri Mother of the Year by the Missouri Mothers Association.

Mrs. Lederer, the mother of four children, is the wife of Dr. Charles A. Lederer. A past-president of the Woman's Auxiliary to the Johnson County Medical Society, she is a member of the Warrensburg R-VI Board of Education and numerous civic organizations.

Mrs. Lederer will be honored at an awards dinner in Jefferson City on April 27 and will compete at the annual conference of American Mothers Committee in New York City on May 7.

Directory 'misleading'

An organization using the title, "U.S. Medical Directory," has been writing to physicians throughout the U.S. soliciting their listing in a *Roster of Participating Medical Doctors in the United States* — for a fee of $10.

Physicians are advised that this publication is *NOT* the official directory of any government agency or the AMA. Postal authorities in Miami, Fla., are currently investigating the organization.

Manpower Conference

A "Statewide Health Manpower Conference," sponsored by the Governor's Advisory Council for Comprehensive Health Planning, will be held April 22-23 in Jefferson City.

The purpose of the Conference is to create an awareness of needs and resources which could further the development of state and local health manpower programs and coordination.

Along with examining recent national, regional, state and local developments affecting health manpower, workshops will be held in seven specific areas: Family Practice, Dental Manpower, Nursing, Allied Health, Manpower Long-Term Planning, Education Coordination and Environmental Health.

Physicians interested in attending should contact Richard McDowell, Department of Community Affairs, 505 Missouri Blvd., Jefferson City, Mo. 65101, for further information.

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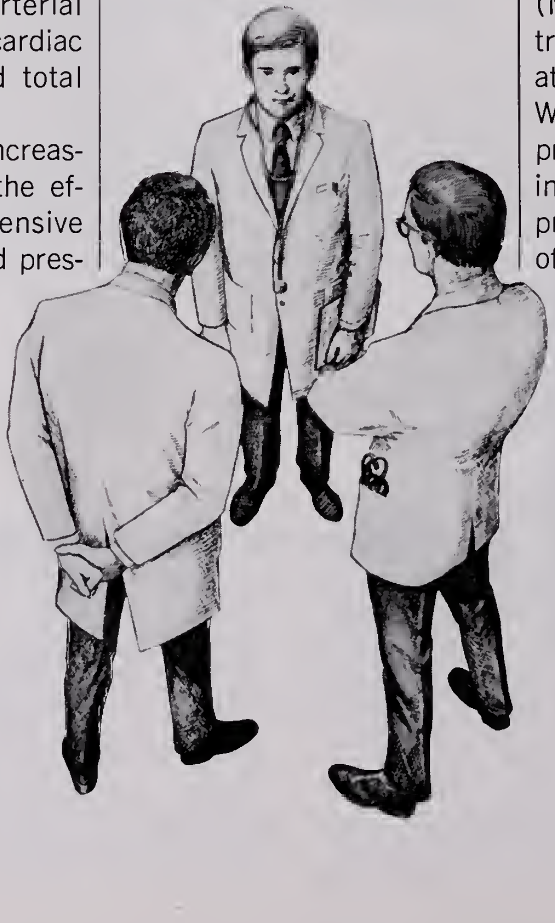
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



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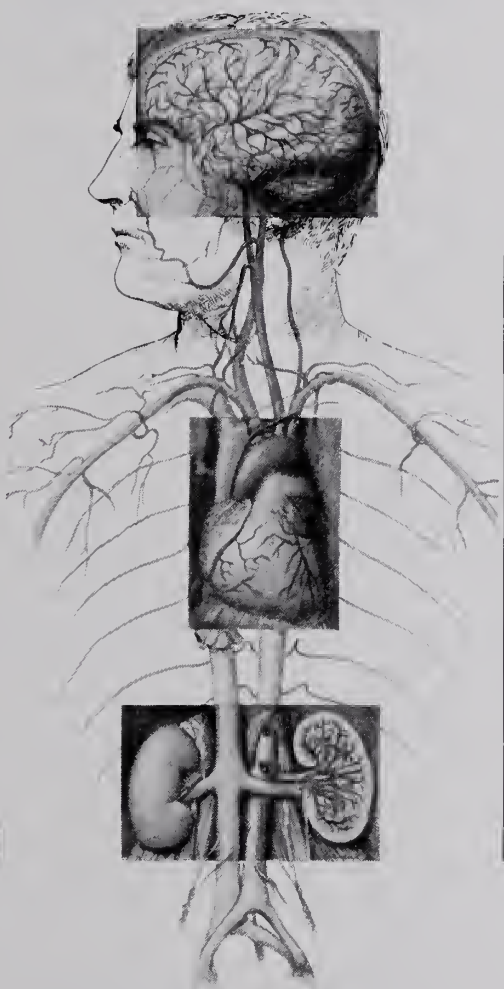

lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Some patients on continuous methyldopa therapy may develop a positive direct Coombs test. For more details, see the brief summary of prescribing information.

Contraindicated in active hepatic disease and known sensitivity to the drug. Not recommended in pheochromocytoma or pregnancy. It should be used with caution in patients with a history of liver disease or dysfunction. Discontinue the drug if fever, abnormal liver function, jaundice, or acquired hemolytic anemia occurs.

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For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: Acquired hemolytic anemia has occurred rarely in association with therapy with methyldopa. Should clinical symptoms indicate the possibility of anemia, hemoglobin and/or hematocrit determinations should be performed. If anemia is present, appropriate laboratory studies should be done to determine if hemolysis is present. Evidence of hemolytic anemia is an indication for discontinuation of the drug. Discontinuation of methyldopa alone or the initiation of adrenocortical steroids usually results in a prompt remission of the anemia. Rarely, however, fatalities have occurred.

Some patients on continued therapy with methyldopa develop a positive direct Coombs test; incidence reported has averaged between 10% and 20%. It rarely occurs in first six months of therapy, and if not seen within twelve months, is unlikely to develop with continued administration. Positive Coombs test is dose-related; lowest incidence occurs in patients on 1 g methyldopa or less per day. Reversal of the positive Coombs test occurs within weeks to months after discontinuation of methyldopa. Prior knowledge of a positive Coombs reaction aids in evaluation of cross match for transfusions. Patients with positive Coombs tests at time of cross match may exhibit incompatible minor cross match. When this occurs, an indirect Coombs test should be performed. If negative, transfusion with blood otherwise compatible in the major cross match may be carried out. If positive, advisability of transfusion with blood compatible in major cross match should be determined by hematologist or expert in transfusion problems.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsy in several patients with liver dysfunction has shown microscopic focal necrosis compatible with drug hypersensitivity. Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen; reversible agranulocytosis has been reported. Methyldopa may interfere with measurement of creatinine by alkaline picrate method and of uric acid by phosphotungstate method. When used with other antihypertensive drugs, potentiation of antihypertensive action may occur.

Usage in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Perform periodic hepatic function tests and white cell and differential blood counts during first six to twelve weeks of therapy or in unexplained fever. Discontinue if fever, abnormalities in liver function tests, or jaundice appears. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Discontinue drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Anesthetics requirements may be reduced; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension may occur after dialysis because methyldopa is removed by this procedure.

Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Do not exceed recommended daily dose of 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure, including dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency, are seen occasionally. Angina pectoris may be aggravated. Symptoms of orthostatic and exercise hypotension may occur; if symptoms occur, reduce dosage. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distension, constipation, flatus, and diarrhea occur occasionally; these can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently; if edema progresses or signs of pulmonary congestion appear, discontinue drug. Rarely, urine exposed to air may darken due to breakdown of methyldopa or its metabolites. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, reversible thrombocytopenia, drug-related fever and abnormal liver function studies with jaundice and hepatocellular damage (see **Warnings** and **Precautions**), rise in BUN, and a single case of bilateral Bell's palsy.

Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

ADDENDU

MS
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Let's make blood pressure "required reading" for all physicians.

With recent estimates that about 23 million Americans have high blood pressure—and that half of them are not even aware of it—detection of the problem in asymptomatic persons has become an issue of national importance.

Family physicians are being urged to take blood pressure readings as a matter of office routine, regardless of the presenting complaint or the reason for the visit. And because many people do not see a family physician for relatively long periods of time, some experts are suggesting that ophthalmologists, gynecologists, dermatologists, orthopedists, psychiatrists, dentists, school nurses, family planning counselors, and other health-care personnel make blood pressure reading a routine part of every examination or consultation.

Of course, a diagnosis of hypertension cannot be made on the basis of a single reading, but routine blood pressure readings can uncover potential trouble in a certain proportion of patients. And when trouble is suggested, further evaluation can be pursued more effectively.

Blood pressure—
"required reading
for all physicians

ALLEN P. KLIPPEL, M.D., ***St. Louis***

The Need for a Mandatory Seat Belt Law

In discussing the need and urging support for a mandatory seat belt law in Missouri, Dr. Klippel emphasizes the imminent importance of changing our sights to prevention of automobile accident injuries instead of the cure in order to alleviate the suffering of the injured and decrease the rate of deaths. Dr. Klippel is Director, Emergency Medical Services, Department of Health and Hospitals, St. Louis.

During the past several years, physicians who are interested in emergency care have been concentrating their activities on the *post facto* management of the acutely ill and injured. There is no denying that progress has been made. Still, much remains to be done if we are to actually alleviate the suffering of the injured and decrease the rate of deaths.

We must change our sights to prevention instead of cure. This is a fatuous remark since in many areas of emergency, such as myocardial infarctions, there are almost as many theories regarding the cause and possible prevention of coronary occlusion as there are specialists in the field. However, there is a program that already has achieved gratifying results even though it is largely ignored by the motoring public. It is the use of lap-and-shoulder restraint belts. Unfortunately, efforts to force people to use seat belts to prevent injuries and death are about as popular as efforts to prohibit cigarette smoking to cut the risk of cancer of the lung.

It is projected that only about 20% of the adult population regularly uses a lap belt and only 2% to 5% regularly uses a shoulder restraint. The introduction of ignition-locking mechanism probably has increased the use of restraints, yet the majority of people writing letters to Congressmen today are demanding the repeal of the locking-mechanism requirement.

In Australia, where the use of restraints has been required for several years, the fatality rate in auto accidents has decreased by 16%, while vehicle use has increased. In a study reported by Huelke from the University of Michigan, auto accidents are compared in reference to the vehicles, speeds and other factors. From this study, it was concluded that the injury rate was 70% for unbelted occupants, 26% for those wearing lap belts and only 3% for those wearing both lap and shoulder restraints.

The Volvo Corporation of Sweden did a statistical analysis of 28,000 auto accidents involving 37,511 people. The conclusion was that with restraints, the front-seat-occupant injury rate was reduced from 40% to 90% depending largely upon the speed.

Restraints also protect people from ejection from the vehicle, which carries a 50% mortality rate. The Volvo Company also found no fatalities in accidents when speeds were up to 60 miles per hour and when the occupants wore both lap and shoulder harnesses.

Some persons argue that the restraint systems are of value only to those involved in accidents and consider the airbag system as preferable since the bags deploy only on impact. They have forgotten a number of facts, as follows:

1. Airbags have little value in roll-over accidents.
2. Airbags deflate after the impact. If the car strikes another car and then runs into a ditch or against another car or bridge support, protection was available only for the first impact. There would be no protection for the second impact.
3. Airbags are of no value to the child who might not be seated in the proper position. In fact, airbags have projected child dummies from the right front of the car into the rear window when the dummy was in a standing position and leaning on the right side of the dash board (a frequent position for small children).
4. The airbag system must be completely replaced after each discharge at a cost of $250.
5. Airbags may fracture eyeglasses and may, themselves, be a source of injury.

As a matter of fact, even if the airbag restraint system is adopted, seat and shoulder harnesses would still be required for the above first three reasons if the airbag system would be triggered only by severe impacts.

Persons who argue that a law requiring the use of seat belts is a threat to the freedom of the individual should be reminded that they also are required to obey speed laws, drive only on their side of the road and wear helmets when operating a motorcycle. In effect, they already must comply with auto regulations which are shown to be for the public good. Their claim that it is only their own lives and property that they endanger is specious since the belted driver may be spared for a subsequent evasive maneuver which may prevent secondary collisions.

If a mother has securely belted her child, she is less likely to have her attention diverted from driving by the child's climbing around the car. Even if the unbelted driver is alone and involved in a one-car accident, his resulting increased injuries will require more tax money for his extrication by the fire services, transport by ambulance personnel to the hospital or morgue and time required of physicians, nurses and other health care personnel. Anyone who lives in a community of two or more people must relinquish some of his freedom to do as he pleases because he must consider the welfare of other people, also.

A financial aspect germane to the use of seat and shoulder belts is to be considered. In some damage suits, awards to injury victims have been reduced if they were unbelted since it was considered that they were adjudged guilty of contributory negligence. Also, large financial rewards are available to any state which enacts statewide mandatory seat-belt legislation. An incentive program of grants to states with such laws is found under Section 402, Page 1,213, Title 24, Code of Federal Regulations (National Highway Traffic Safety Administration). A state can have its allocation of highway safety funds increased by 10%, 15% or 25%, depending upon the type of legislation it enacts.

For a 10% increase, a state would have to require that each front seat occupant of age 16 and older use a lap belt if the vehicle is equipped with belts (removal of an installed belt would equal a violation of the code). The driver would be responsible for himself and all passengers up to the age of 16. A passenger more than 16 years of age must be considered responsible for himself and, therefore, would personally be liable for the penalty.

To qualify the state for the 15% grant, the state law would have to require each front-seat passenger and driver of age 16 or older to wear both a lap and shoulder belt if the car were equipped with them. A child six years old but less than 16 years old would be required to wear only a lap belt.

The 25% increase in grant money would be awarded to those states which enact legislation requiring the use of lap belts by all occupants of the vehicle who are six years and older and the use of lap and shoulder belts by all occupants who are 16 years and older if the vehicle is equipped with them. These incentive grants take into account the fact that many older cars are not equipped with belts and no penalty is assessed if the vehicle did not have factory-installed belts.

It is the role of organized medicine to involve itself in preventing death and injury. There can be no better example of such activity than the promulgation of a mandatory seat belt law by the General Assembly of Missouri. As physicians, we should contact our state representatives and encourage their support for this type of legislation.

Continuing Education Coming Events

April 15-17	**Symposium: Ophthalmology: Diagnosis and Treatment of Orbital Diseases** Postgraduate Medical Education K.U. School of Medicine, Kansas City, Kan.
April 22-23	**Symposium: Recent Advances in Obstetrics and Gynecology** Clompton Auditorium, Washington U. School of Medicine St. Louis
April 25-26	**Workshop: Clinical Approach to Allergic Disorders** St. Louis U. Medical Center Continuing Education Miller Hall, St. Louis
April 26	**Symposium: Infectious Diseases** Postgraduate Medical Education K.U. School of Medicine, Kansas City, Kan.

(Continued on page 194)

WASHINGTON

The American Medical Association has announced the filing of a lawsuit against the Cost of Living Council to seek an end to all economic controls on medicine.

At a news conference in the AMA-Washington office, the organization disclosed that it is seeking an injunction against the Phase IV regulations on physicians and hospitals. It charged that the rules are "confiscatory, arbitrary and capricious," that they violate the "generally fair and equitable" standard established by Congress and that they violate the Fifth Amendment of the U. S. Constitution.

Announcement of the legal action was made by Russell B. Roth, M.D., President of the AMA, and James H. Sammons, M.D., Chairman of the AMA Board of Trustees.

In its complaint stating its legal action, the AMA pointed out that the Phase IV regulations represent an "attempt to mold the health care delivery system to comport with the CLC's concepts for health care" and are specifically designed "to curb the quantity and quality of health care services as an integral part of the legislative program to induce Congress to enact national health insurance."

The AMA asked that the court declare these Phase IV regulations invalid and enjoin the Cost of Living Council from enforcing them.

In his statement, Dr. Roth said the AMA is filing in U. S. District Court, District of Columbia, a suit seeking an injunction against the Cost of Living Council. "We are asking the court to declare invalid the Phase IV regulations as applied to physicians and hospitals on the grounds that they are confiscatory, arbitrary, capricious and discriminatory.

"We further believe that they violate the very law on which they are based in that they do not conform to the 'generally fair and equitable' standard written into the law by the Congress.

"Finally, we believe that they violate the most fundamental law of the land—the Constitution of the United States in that they confiscate the property of physicians and hospitals without due process of law, a clear infringement of the fifth amendment.

"Those are the legal tenets on which we are basing our case. We are convinced that they are valid and sound and that they will prevail in the courts.

"But while we proceed on legal grounds, I think it is important to point out that we believe the issues involved are far broader than mere legalisms and that they cast their shadows far beyond the limited scope of Phase IV.

"They are issues of principle and they have profound implications for the future of health care in this country."

* * *

One day after the AMA filed its suit against the Cost of Living Council, President Nixon reaffirmed the Administration's intention to keep cost controls on hospitals and physicians until a national health insurance program is approved.

In a second message on health submitted to Congress, the President also emphasized a shift in policy on health education from operating subsidies to direct assistance to students. Nixon said, "The nation's total supply of health professionals is becoming sufficient to meet our needs during the next decade. In fact, oversupply in the aggregate could possibly become a problem."

On controlling health costs, the President said, "We must avoid the cost inflation which followed the introduction of Medicare and Medicaid. Our health insurance proposal would call for states to oversee the operation of insurance carriers and establish sound procedures for cost control. Until these or other controls are in place, I recommend that our present authorities to control health care costs be continued. I am asking the Congress for such authority." Inflationary pressures are still strong in the medical field, he said, "so that we must maintain federal controls until other measures are adopted under comprehensive health insurance."

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Before prescribing, see complete prescribing information in SK&F literature or *PDR.* The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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Missouri Medicine

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ROBERT L. JACKSON, M.D. *and*
D. Y. N. MURTHY, M.D., ***Columbia***

Importance of Early Insulin Treatment and Good Regulation of Children With Diabetes

AN EVER-INCREASING NUMBER of juvenile diabetics are finding themselves handicapped by progressive vascular disease in early adult life. The insidious development of these serious complications over a period of years indicates that, too often, the disease is managed inadequately.[1]

In 1956, Jackson and Hardin reported their findings on a group of 140 juvenile diabetic patients observed at the University of Iowa with a duration of their disease ranging from ten to 29 years.[2] They found that the degree of control of the diabetes was the only identifiable factor bearing a constantly significant relationship to the incidence and severity of vascular complications. Clinically, anatomically and biochemically, evidence is accumulating that the vascular complications of diabetes are related to high blood glucose and low serum insulin levels, that is, the degree of regulation of diabetes.[3-6]

Electron microscopic measurements of the capillary basement membrane (CBM) obtained by muscle biopsy in our clinic[7] are in keeping with the findings of Kilo *et al*[8] that capillary basement membrane thickening (CBMT) does not precede the onset of carbohydrate intolerance, but the rate of development is related to the degree of control of the diabetes. In preliminary studies, we have observed that CMBT develops in less than five years in children with poorly controlled diabetes but may not develop even after 17 years in children with well controlled diabetes. The CBMs of children with poorly controlled diabetes of less than five-years duration were thicker than the CBMs in children with well controlled diabetes of more than 15 years.

The onset of overt diabetes in children constitutes a serious problem and should receive immediate attention. (Overt diabetes refers to the clinical syndrome of hyperglycemia, glycosuria, polydipsia and polyphagia.) The term "insulin deficient" or "insulin dependent" often is applied to the juvenile type of diabetes. The child who presents with classical signs and symptoms of diabetes has very low basal insulin levels with decreased insulin release after islet cell stimulation and a low endogenous insulinogenic reserve.[9] When overt diabetes mellitus occurs in childhood, the symptoms of acute insulin deficiency usually are definite and appear abruptly, especially if the child has an acute infection. The child or parents usually can recall the week or even the day when symptoms were first noticed. For a few weeks or months after the onset of the clinical disease, the increased intake of food and liquids compensates for the urinary losses, and mild ketosis may be tolerated even though increased catabolism and defective protein synthesis interferes with normal growth. Ketonemia gradually increases, finally causing anorexia and vomiting, after which ketoacidosis develops rapidly.

The biochemical alterations characterizing the child with overt diabetes result from insulin deficiency. Insulin deficiency produces a metabolic state similar to that of starvation. Without insulin, food cannot be stored effectively for future use.

There is (1) inhibition of peripheral glucose uptake; (2) decreased synthesis of glycogen, protein and lipid; (3) reversal of the glycolytic pathway with active hepatic production of glucose from amino acids despite the presence of hyperglycemia; (4) active mobilization of fats from adipose tissue, leading to marked elevation in the concentration of total lipids, cholesterol, triglycerides and free fatty acid in plasma; and (5) development of diabetic ketoacidosis.

In our opinion, most children with overt diabetes receive delayed and inadequate treatment at the time of onset of symptoms. Most often, they are treated like adult diabetic patients and, at first, are advised only to modify their diet. When this is found to be inadequate, they also are given a single daily dose of an intermediate type of insulin. Some children are even submitted to an ineffective therapeutic trial with oral hypoglycemic agents. Many studies indicate that oral hypoglycemic agents, such as tolbutamide and phenformin, are not effective for the treatment of children with overt diabetes.[10]

Since most diabetic children are still producing varying amounts of endogenous insulin during the early weeks or even months after onset of the disease, they will have a good response to an improved diet and only a single daily injection of insulin. To control the disorder completely, however, they need at least two daily injections of insulin and a structured meal plan. If they receive suboptimal treatment with only a single dose of insulin, the insulin deficiency gradually progresses. Consequently, the morning dose of insulin is increased to control glycosuria and nocturia. The child then begins to experience hypoglycemic episodes of varying intensities usually during the late morning or early afternoon. The child is then considered to have complete or total (brittle) diabetes with the added possibility of a convulsive disorder. It is not until this time, when the condition has progressed to total diabetes, that many diabetic children are referred for specialized care.

Every child with overt diabetes should receive insulin therapy as soon as the diagnosis is confirmed. The exogenous insulin requirement varies, depending upon how early the diagnosis is made and how soon insulin is given. The earlier the diagnosis is made, the lower the amount of insulin needed and the easier it will be to attain and maintain a high degree of control with little risk of hypoglycemia.[11]

It is an established fact, but not fully appreciated, that with prompt insulin treatment, the exogenous insulin requirement of most children with recent onset of diabetes decreases rapidly to a relatively low level (0.05 to 0.20 units per lb/day). The insulin requirement is low because the child's pancreas is still able to produce some endogenous insulin. This state of partial remission persists for a variable period of time and is known as the "honeymoon period." During the period of partial remission, glycosuria can be controlled completely with two small doses of insulin daily and with little likelihood of even a mild insulin reaction. Maintaining a high degree of control may prolong the remission period for several years. This "honeymoon period" also provides assurance to the family and the child that the diabetes can be controlled completely and that diabetic children can lead active normal lives.

As previously stated, with inadequate therapy, the disease progresses over a short period of time (months) and the pancreas gradually loses its ability to produce any insulin. The child then has complete or total (brittle) diabetes which is an advanced stage of the disease. To maintain a good-to-fair degree of control, the children with total diabetes have to receive at least two daily injections of insulin and proper meal planning which distributes their caloric intake into three meals and three snacks. We have often stated that it is not the diabetes that is brittle; it is the doctors who are brittle and unwilling or reluctant to modify the treatment plan to meet the needs of young patients with total insulin dependent diabetes.

In contrast to children with recent onset of diabetes, children with complete or total (brittle) diabetes will not experience a remission with improved control of their disease. Their daily insulin requirement is high, ranging from about 0.4 units to 1.0 units per lb/day, and it is necessary to permit them to have at least transient glycosuria in order to avoid serious insulin reactions.

In our experience, at least two daily injections of insulin are needed for optimal treatment of all children with diabetes. In our clinic, a mixture of two parts of NPH insulin and one part of neutral regular insulin is given one-half hour before breakfast and one-half hour before the evening meal. Two thirds of the total dose is given before breakfast and the remaining one third is given before the evening meal.[12] We prefer using more purified insulin preparations, i.e., single peak NPH and neutral regular insulins, since these newer insulin preparations[13] do not produce lipoatrophic areas at the injection sites.[14] Because they have essentially the same pH, NPH and neutral regular, insulins can be premixed in a bottle. Premixing larger volumes of NPH and regular insulins in a bottle provides greater accuracy and convenience than mixing smaller individual doses of insulins in the syringe at the time of injection.

The maintenance diet of the child with diabetes should be essentially the same as for normal children. In the initial instruction to the parents and the child, it is most important to teach them how to use high quality, common foods in preparing simple menus. The only difference in the diabetic child's dietary program as compared to the nondiabetic child's program is that meals are planned to provide a relatively predictable caloric intake. The food intake also needs to be varied according to the physical activity of the child.[15]

Most children with complete or total (brittle) diabetes will have a good response to the plan of treatment outlined. It provides insulin throughout the day (24 hours) with sufficient insulin available at the appropriate times so that the child can eat meals and snacks in keeping with the usual eating habits of most nondiabetic children. Some patients with total diabetes will have an improved response to more frequent injections of regular insulin given 20 to 30 minutes before breakfast and the noon meal and a two-to-one mixture of NPH and regular insulin given prior to the evening meal.

During a febrile illness, the insulin requirement usually increases provided that the child continues to ingest and absorb his food. In addition to needing somewhat larger doses of insulin in the morning and evening, the child also may require supplementary doses of *regular insulin* at noon or late in the evening. If the second voided urine specimen at noon contains more than 3% sugar, we advise the parents to give one sixth of the amount of insulin the child received for the morning dose and to double the dose if the urine also has a positive test for ketones. Again, if the late-evening, second voided urine specimen contains more than 3% sugar, we advise that they give one fourth of the amount of insulin the child received before the evening meal and to double the dose if the urine has a positive test for ketones. It is important to stress that insulin should never be discontinued because the child is not eating well or has vomited food. It is necessary to modify the diet so that the child gets small amounts of foods at frequent intervals such as sweetened carbonated drinks (7 Up), fruit juices, sherbet, jello, custard and skimmed milk.

Children with overt diabetes should be hospitalized not only for the treatment of acute complications, such as ketoacidosis or a severe insulin reaction, but also to reestablish nutritional status, to determine the maintenance insulin requirement and to educate both the parents and the child. To attain these goals, the undernourished young diabetic patient usually requires hospital care for about three weeks. A hospital school should be available so that the child can continue his education. In addition to expert medical care, the child and family need to receive intensive education from a nurse and a dietitian experienced in management of children with diabetes. Detailed social information is needed to determine the family and community resources. The combined efforts of the health team are needed to evaluate and prepare the family to continue the regime after the child returns home.

In the opinion of the authors, most children with overt diabetes receive delayed and inadequate treatment at the time of onset of symptoms. They stress that the onset of this complication in children constitutes a serious problem requiring prompt treatment with insulin and diet. The combined efforts of a health team also are needed to evaluate and prepare the family to continue the regimen after the child returns to his home. Dr. Jackson and Dr. Murthy are from the Department of Pediatrics, University of Missouri School of Medicine.

If the child is to make a good adjustment, the family, as well as the community, needs to be educated by the family physician with the help of a public health nurse. Most diabetic children from stable family settings continue to do very well if they receive early treatment and the parents understand how to continue the program of management under home conditions. We rarely have to readmit such a child to the hospital. Diabetic children receiving suboptimal care often require rehospitalization at frequent intervals.

There is a growing body of evidence that the glucose tolerance test in children may be abnormal (chemical diabetes) for years before the onset of clinical or overt diabetes.[16] (Chemical diabetes refers to a state in which there is an asymptomatic abnormality of carbohydrate metabolism detected by an oral glucose tolerance test.) In the early stages of chemical diabetes in children, an increased insulin response to an oral glucose load has been found with normal or only minimal abnormalities in the blood sugar values. More often, a delayed release of insulin is observed with elevated insulin values about three hours after ingestion of a standard oral glucose load. As the disease progresses, there is a progressive decrease in insulin response with associated hyperglycemia and soon after symptoms of overt diabetes develop. Consequently, we have given small doses of insulin (0.05 units to 0.10 units per lb/day) to a few children with late chemical diabetes, and the dosage of insulin needed to maintain normoglycemia has remained very low for many years.[17] Our studies of children with a definite family history of diabetes (with first degree diabetic relatives like sibling(s) or parents) verifies the importance of doing an oral glucose tolerance test under standard conditions and evaluating both blood sugar and insulin response curves.

Recent advances in diabetes research have been encouraging. We are looking forward to the day when we will know the cause of the disease and how to prevent it. Until then, early institution of insulin treatment of children with diabetes needs to be better appreciated. Until more knowledge is available, good control of the disease offers the only means of delaying or averting degenerative changes.

Summary

Recent clinical and research investigations at the Pediatrics Department of the University of Missouri Medical Center in Columbia confirms the importance of a high degree of control of children with diabetes in order to delay (or even prevent) the development of serious vascular complications. The onset of overt diabetes in a child should be considered a serious problem requiring prompt treatment with insulin and diet.

Institution of insulin therapy and careful meal planning as soon as the diagnosis is confirmed permits complete regulation of the disorder with freedom from glycosuria and insulin reactions and with essentially normal diurnal blood sugar levels.

Hospitalization for a period of weeks is needed not only to reestablish the nutritional status and determine the insulin requirement but, also, to educate the parents and the child. In addition to expert medical care, the child and family need to receive intensive education from a nurse and a dietitian experienced in management of children with diabetes. Detailed social information also is needed to determine the family and community resources. The combined efforts of a health team are needed to evaluate and prepare the family to continue the regimen after the child returns home.

Too many children with diabetes are treated as little adults and receive inadequate treatment at the time of onset of the disease. With suboptimal treatment, the insulin deficiency gradually increases and within a few months the child loses the ability to produce any insulin. The child then has total or brittle diabetes. The child with total diabetes has to be allowed minimal transient glycosuria in order to avoid serious insulin reactions. Even in these children, however, a fair to good degree of control can be attained with two daily insulin injections and proper meal planning.

Facilities are available in the Pediatric Department at the University of Missouri to provide optimal care for children with diabetes and for detailed instruction of their parents for home management.

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Subacute Intravascular Coagulation With Prostatic Carcinoma

Case Reports

DISSEMINATED INTRAVASCULAR COAGULATION has been recognized most frequently by the urologist as an acute, fulminant bleeding disorder in a critically ill patient with sepsis. Less generally appreciated is the occurrence of this clotting abnormality in a subacute or chronic form usually appearing in the presence of advanced malignant disease.

We have had two recent experiences with subacute, disseminated intravascular coagulation (DIC) in patients with metastatic adenocarcinoma of the prostate. The salient features of these two cases were a several-month history of a mild bleeding tendency with ease of bruising, mild hematuria and, in one instance, nosebleeds. With the exception of thrombocytopenia, routine coagulation studies were normal. Severe bleeding, which appeared after an apparently minor procedure to the lower urinary tract, was initially ascribed to thrombocytopenia ostensibly related to bone marrow replacement by tumor. Additional clotting studies and the reversal of bleeding with intravenous heparin clearly identified the problem as one of DIC.

We would like to emphasize the diagnostic subtleties of the condition, to point out the hazards of even seemingly minor urological procedures under such circumstances and to reiterate the value of low dose heparin in the reversal of this clotting abnormality.

CASE REPORTS

Case #1. A 68-year-old man presented with a long history of alcoholism and several years of obstructive prostatic symptoms. Four weeks before admission, he noted ease of bruising and almost nightly nosebleeds. Significant admission physical findings were an enlarged nodular prostate, scattered bruises, petechiae over the skin and a moderately enlarged liver. The acid phosphatase was 128 units/100 ml (normal, 5 to 15 units) and the alkaline phosphatase was 258 units/100 ml (normal, 20 to 70 units). The hemoglobin value was 10.4 gm/100 ml; hematocrit reading, 30%; white blood count 7,000/cu mm; prothrombin time (PT), 14/12 seconds; activated partial thromboplastin time (APTT), 27/33 seconds; and the platelet count, 44,000/cu mm. X-rays showed diffuse blastic metastases.

An apparently uncomplicated urethral catheterization was performed the following day with the development of profuse hematuria. Additional clotting studies (Fig. 1) showed normal thrombin time (TT) with a low fibrinogen and a positive test for cryofibrinogen and fibrin split products in the plasma. A bone marrow biopsy showed metastatic carcinoma.

In spite of transfusion, the hematocrit reading fell to 21% by the following day and the patient was placed on a regimen of 50 units/Kg or heparin administered intravenously every six hours and 1 gm of diethylstilbestrol diphosphate administered intravenously daily. By the third day of therapy, the platelets had fallen to a low of 22,000/cu mm. All other clotting studies were normal. Continued bleeding necessitated a total of 5 units of blood. Three days later, the bleeding ceased although heparin therapy was continued for a total of 14 days with a rise in platelets to 86,000/cu mm. Needle biopsy of the prostate and bilateral orchiectomy were performed without incident four days later and the patient was discharged on a regimen of estrogens.

COAGULATION STUDIES (PATIENT #1)

Study	*Normal Values*	*Initial*	*2-3 Weeks*	*1 Year*
Prothrombin time (seconds)	11-14	14	13	
Activated partial thromboplastin time (seconds)	25-35	27	29	
Thrombin time (seconds)	15-20	18	15	
Fibrinogen (mg%)	200-400	<200	>200	
Platelet count (thousand/mm^3)	200-400	44	86	178
Fibrin split products	Negative	Positive	Negative	
Euglobulin lysis time (minutes)	>120	>120		
Cryofibrinogen	Negative	Positive	Positive	

Fig. 1

The authors report two recent experiences with subacute disseminated intravascular coagulation in patients with metastatic adenocarcinoma of the prostate. They discuss diagnostic subtleties and treatment of this clotting abnormality in a subacute or chronic form which usually appears in the presence of advanced malignant disease. Drs. Ross, Thompson and Samaha are from the Section of Urology and Section of Hematology, University of Missouri School of Medicine.

Four weeks after discharge, the hematocrit level was 26%, platelet count was 210,000/cu mm and the test for fibrin split products was negative although cryofibrinogen was still present. The acid phosphatase had fallen to 9 units. Transurethral prostatectomy was performed without difficulty.

One year later, the patient required local radiation therapy for a painful shoulder metastasis. His acid phosphatase had risen to 183 units, but the platelet count remained stable at 178,000/cu mm. There had been no evidence of a bleeding tendency during the year.

Case #2. A 54-year-old man had a stable, mild alcoholic cirrhosis and a history of duodenal ulcer that required gastrectomy three years earlier. There had been ease of bruising for several weeks prior to admission. The only significant admission physical findings were scattered ecchymoses and a hard, nodular prostate. Admission laboratory studies were normal with the exception of an elevated acid and alkaline phosphatase which were 17 units/100 ml and 350 units/100 ml respectively. X-ray examination showed diffuse blastic and lytic involvement of the spine and pelvis.

Transrectal prostatic biopsy was performed and, subsequently, reported as adenocarcinoma. Six hours later, brisk bleeding necessitated packing of the rectum. The following day the hematocrit reading had fallen to 28%. Coagulation studies were within normal limits with the exception of a slightly prolonged thrombin time and the presence of fibrin split products and cryofibrinogen in the plasma (Fig. 2). The platelet count was 118,000/cu mm. He was started on a regimen on 25 units/Kg of heparin intravenously every six hours. This was later raised to 50 units/Kg because of recurrent rectal bleeding requiring the transfusion of 2 units of packed cells.

COAGULATION STUDIES (PATIENT #2)

Study	*Normal Values*	*Initial*	*2-3 Weeks*	*1 Year*
Prothrombin time (seconds)	11-14	13	14	12
Activated partial thromboplastin time (seconds)	25-35	30	35	36
Thrombin time (seconds)	15-20	30	24	
Fibrinogen (mg%)	200-400	>200	400	<400
Platelet count (thousand/mm³)	200-400	118	256	115
Fibrin Split Products	Negative	Positive		
Euglobulin lysis time (minutes)	>120	>120		
Cryofibrinogen	Negative	Positive	Positive	Positive

Fig. 2

Bleeding subsequently ceased within 24 hours at which time the platelet count was 136,000/cu mm. The patient was placed on a regimen of estrogens with 1 gm of diethylstilbestrol disphosphate daily. Heparin was continued for 12 days, by which time the platelet count was 210,000/cu mm. The following day he underwent bilateral orchiectomy and bone marrow biopsy with the finding of metastatic adenocarcinoma. Normal iron and megakaryocytes were present in the marrow.

Two months after discharge, he was clinically well with a platelet count of 120,000/cu mm. Cryofibrinogen persisted in the plasma. Six months later, he continues to be asymptomatic with a platelet count of 118,000/cu mm.

DISCUSSION

The DIC state is characterized by a bleeding tendency and the consumption of coagulation elements. It may be acute and severe, or prolonged and relatively mild. The precise dynamics are unknown, but the net effect is an accelerated production of thrombin which, in turn, catalyzes the conversion of fibrinogen to fibrin. The activity of the fibrinolytic system is commensurately increased so that secondary fibrinolysis is a natural consequence of DIC. Unfortunately, the neutralizing capacity of the fibrinolytic system is usually exceeded, and fibrin deposition occurs in the microcirculation compromising the function of many organs. An element of reticuloendothelial system failure may augment the problem by failing to remove activated clotting intermediates and fibrin molecules from the circulation.

Laboratory studies in the acute forms of DIC reflect the intense stimulation of the clotting mechanism with a fall in the platelet count and abnormal clotting tests related to the consumption of clotting intermediates. The PT, APTT and TT are all often prolonged, and there may be a shortened euglobulin lysis time. Fibrinogen levels are reduced and fibrin split products appear in the plasma.

Subacute and chronic DIC are less dramatic manifestations of the same process with a low-grade bleeding tendency and less well defined diagnostic parameters. Most such cases have been reported in conjunction with malignant disease and metastatic carcinoma of the prostate purportedly accounts for about one third of such cases.[1] As the present cases demonstrate, the DIC state with metastatic carcinoma tends to be relatively indolent.

Since minor urological manipulation may instigate severe bleeding in these patients, the recognition of such a low grade DIC state is of immediate importance. Equally significant is the appropriate differential diagnosis between DIC and a primary fibrinolytic state. The platelet count and clotting tests often, though not invariably, allow one to distinguish between a consumptive coagulopathy and primary fibrinolysis (Fig. 3). In the former, the platelet count is low and the tests of plasma fibrinolytic activity, such as clot lysis and the euglobulin lysis time, show only modest acceleration; in the latter, the platelet count is usually normal and the euglobulin lysis time is very rapid. In both instances, fibrinogen is reduced and fibrin split products appear in the plasma.

Unfortunately, the platelet count tends to lose its specificity in metastatic prostatic carcinoma since marrow invasion may reduce platelets without any other factors being involved.

Although postulated as being specific for DIC and negative in fibrinolysis, the presence of inordinately large quantities of cryofibrinogen in the plasma appeared to be equally nonspecific in our patients. In both instances, cryofibrinogen persisted in the plasma long after the episode of DIC had been controlled.

In our own material, the most significant diagnostic features in differentiating DIC from primary fibrinolysis were the relatively long history of a mild bleeding tendency and the euglobulin lysis time which was normal in both instances.

A final and most important step in differentiation is a trial of intravenous heparin to see if bleeding is curtailed and laboratory values are improved. A low dose of 50 units/Kg appears to be adequate and is well below that required for anticoagulation. Should the problem be that of primary fibrinolysis, heparin will in no way exacerbate the problem. If there is no response to heparin, aminocaproic acid may be administered secondarily. On the other hand, aminocaproic acid may be distinctly harmful in DIC since fibrinolysis may be curtailed, exaggerating the effect of intravascular coagulation. In both patients, heparin appeared to be therapeutically effective.

DIFFERENTIAL DIAGNOSIS

Study	*Subacute DIC*	*Primary Fibrinolysis*
Platelet count	↓	Normal
Thrombin time	Normal or ↑	Normal or ↑
Fibrinogen	↓	↓
Fibrin split products	↑	↑
Euglobulin lysis time	Normal or ↓	↓↓
Prothrombin time	Normal or ↑	Normal
Activated partial thromboplastin time	Normal or ↑	Normal
Cryofibrinogen	Present	Absent
Therapeutic trial		
Heparin	Response	No response
EACA	No response (Potentially Hazardous)	Response

Fig. 3

In summary, the patient with carcinoma of the prostate and excessive early postprostatectomy bleeding may be safely treated with aminocaproic acid if the platelet count is normal since DIC would be unusual under such circumstances.

In the event of any reduction in platelets or other clotting test abnormalities, generalized bleeding, a history of bleeding tendency or inappropriately severe bleeding following mild trauma, DIC must be clearly ruled out before considering treatment with agents that inhibit fibrinolysis.

If the process is acute, laboratory studies will usually establish the appropriate diagnosis. DIC with metastatic prostatic carcinoma is much more commonly seen in the clinical setting of a low grade reaction where such studies may be sufficiently ambivalent to necessitate a therapeutic trial of heparin to clearly establish the diagnosis.

In every instance, treatment also must be directed to the underlying cause of the DIC. A response to hormonal manipulation with symptomatic improvement and a fall in acid phosphatase occurred in both patients.

Unfortunately, we were unable to tell if hormonal therapy prevented continued episodes of DIC or if short-term heparin therapy was sufficient to interrupt the low grade activation of the clotting mechanism and restore equilibrium to the hemostatic process.

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M. F. MULLINS, M.B., B.Ch., *Columbia*

Value of Subtraction in Arch Aortography

Case Reports

THE PRINCIPLE OF PHOTOGRAPHIC ELIMINATION or "subtraction" of noncontributory roentgen details and images was first described by Ziedses des Plantes nearly 40 years ago.[1] Since that time, a number of modifications of the original subtraction method have been described[2-9] and many clinical facilities routinely use some type of subtraction technique. The purpose of this paper is to illustrate the value of routine subtraction and to demonstrate that it can easily be employed at a minimum cost in any hospital which performs angiography. In each of the three case reports which follow, a roentgenographic diagnosis was greatly facilitated by the use of subtraction.

CASE REPORTS

Case #1. A 73-year-old white man was admitted with complaints of multiple episodes of dizziness and syncopal attacks. Positive physical findings included a bruit over the right side of the neck and a decreased left brachial pulse. A presumptive diagnosis of stenosis in the area of the right carotid bifurcation was advanced. An aortic arch study revealed a stenosis of the right internal carotid artery at its origin (Fig. 1-A). A subtraction print (Fig. 1-B) of this arteriogram revealed a very high grade stenosis of the right internal carotid and, in addition, an ulcerated atheromatous plaque of the left common carotid artery proximal to the bifurcation which could not be appreciated on the original film. Selective catheterization of the left carotid revealed normal intracranial circulation, and cross-com-

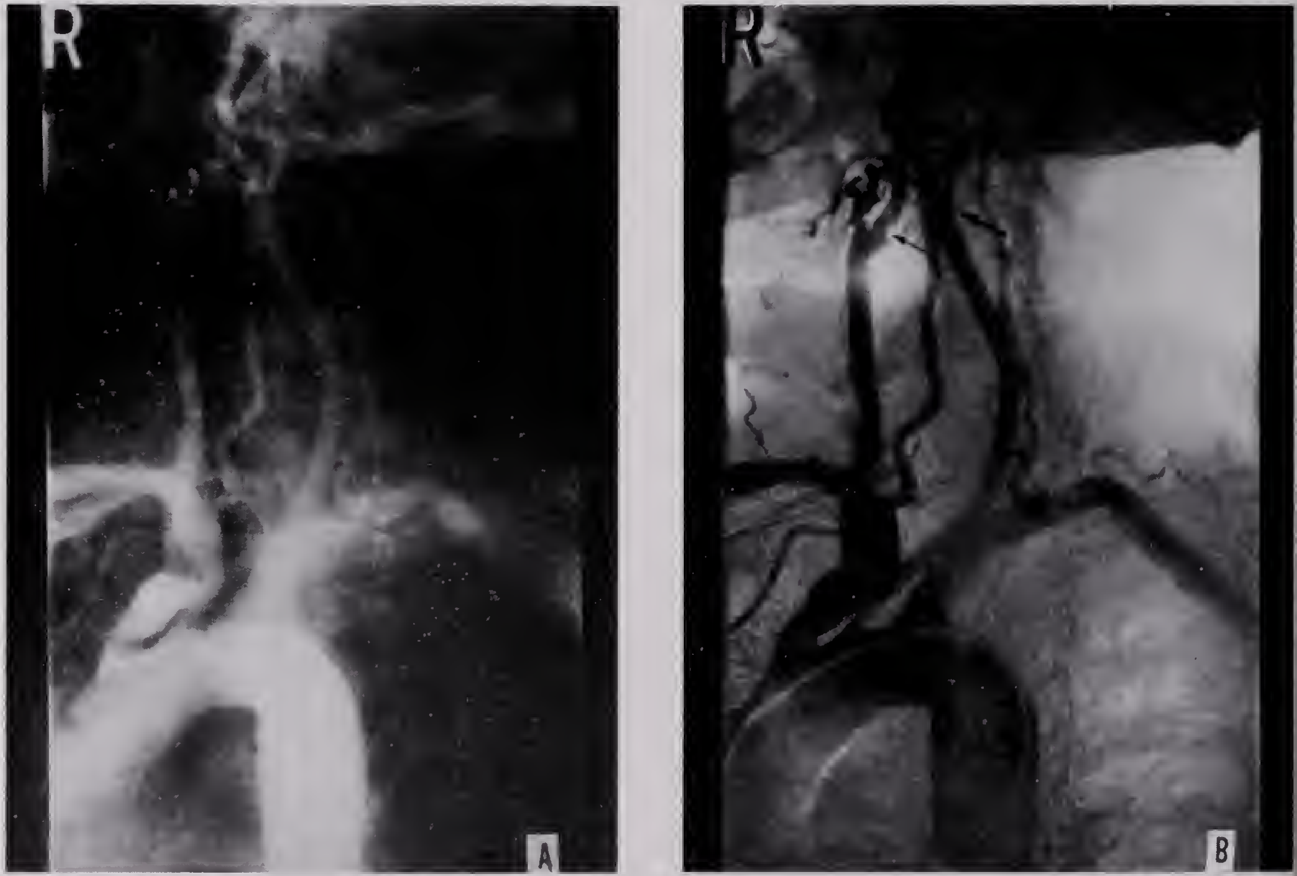

Fig. 1 Case #1. (A) Presubtraction film reveals suspicious area involving right internal carotid. (B) Subtraction film demonstrates high-grade stenosis of right internal carotid artery *(small arrow)*. Note ulcerated atheromatous plaque *(large arrow)* of left common carotid artery.

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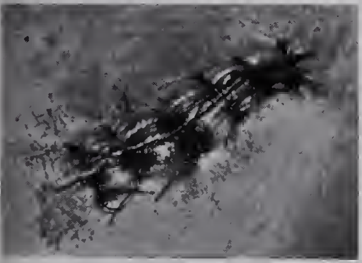

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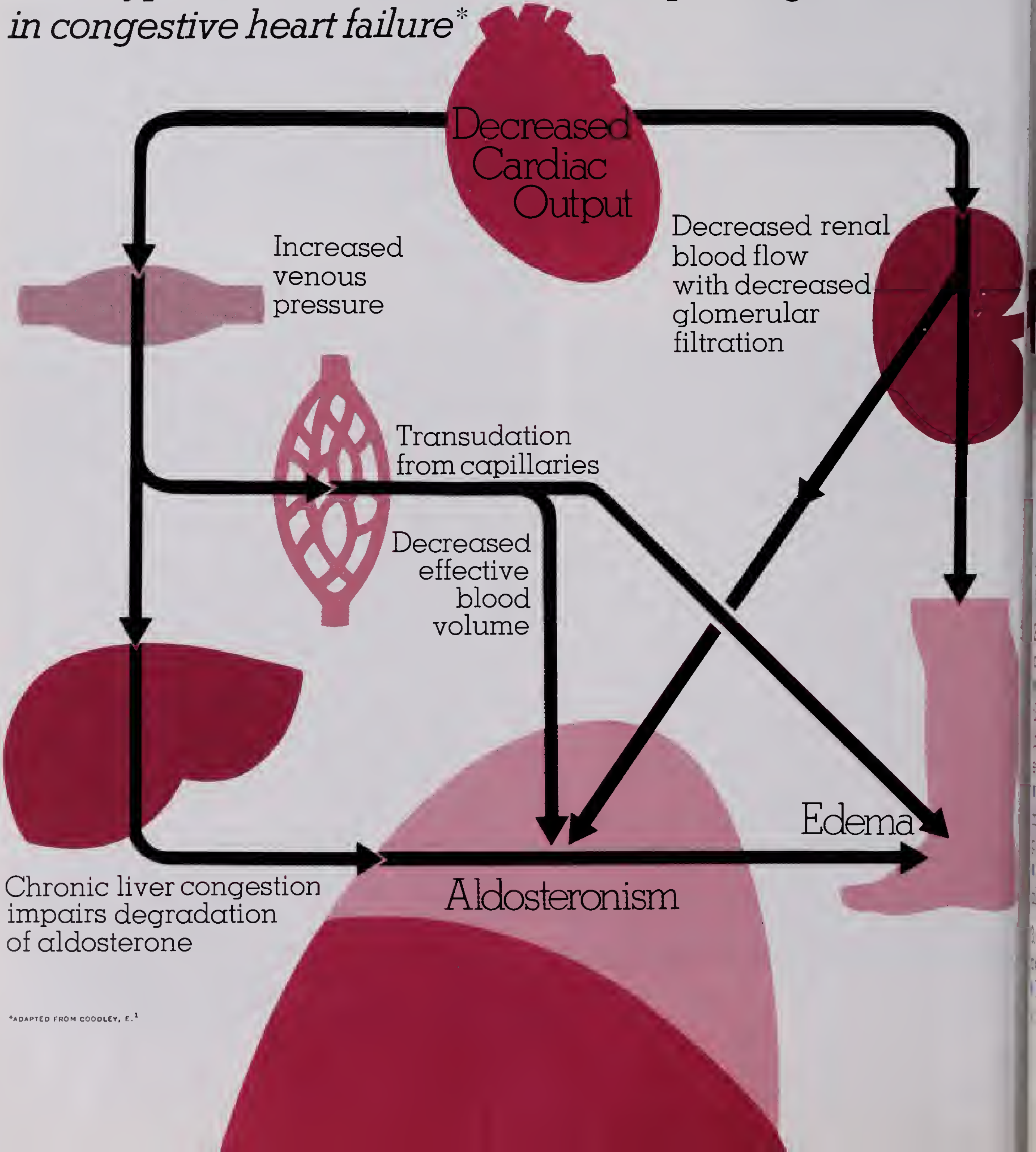
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- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide
- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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Zip____________________

pression of the right carotid revealed good cross-flow via the anterior communicating artery. The ulcerated plaque was repaired first and the stenosis of the right carotid was corrected at a subsequent operation.

Case #2. A 63-year-old white man was admitted with signs and symptoms of basilar and carotid artery insufficiency and aortoiliac occlusive disease. Physical examination revealed motor weakness on the left side and markedly diminished femoral pulses bilaterally. An arch aortogram (Fig. 2-A) was performed and no right vertebral artery was visualized. A subtraction print (Fig. 2-B) revealed an atretic right vertebral artery. Atheromatous nonocclusive disease of both carotid bifurcations also was noted. Since the left vertebral artery was patent, it was concluded that surgery could offer no benefits. The intracranial vasculature was grossly normal.

Case #3. A 54-year-old white woman was admitted with a history of numbness on the right side for six weeks prior to admission. At the time of admission, the numbness had progressed to right lower extremity weakness that repeatedly caused the patient to fall. There was no loss of consciousness associated with these episodes. On physical examination, blood pressure was 130/80. Examination of the fundi showed a 1:2 arteriovenous ratio and a blurring of the left disc margin. Motor function evaluation showed a right hemiparesis. An aortogram (Fig. 3-A) revealed a definite abnormality of the left carotid bifurcation. However, the subtraction print (Fig. 3-B) demonstrated complete occlusion of the left common carotid. This was difficult to appreciate on the original film because of the overlapping course of the right vertebral artery. Examination of the intracranial carotid circulation showed that both hemispheres were perfused from a right carotid injection. Due to the level of the carotid occlusion, surgery was ruled out.

Subtraction technique is a photographic method of eliminating undesirable images from radiographic films. By eliminating the images of overlying bony structures, for example, diagnostically relevant details become apparent. The author reports three cases in which angiographic diagnoses were greatly facilitated by the use of this relatively simple and inexpensive process. Dr. Mullins is Assistant Professor of Radiology in charge of Special Procedures, Department of Radiology, University of Missouri School of Medicine.

Discussion

The cases presented here demonstrate the value

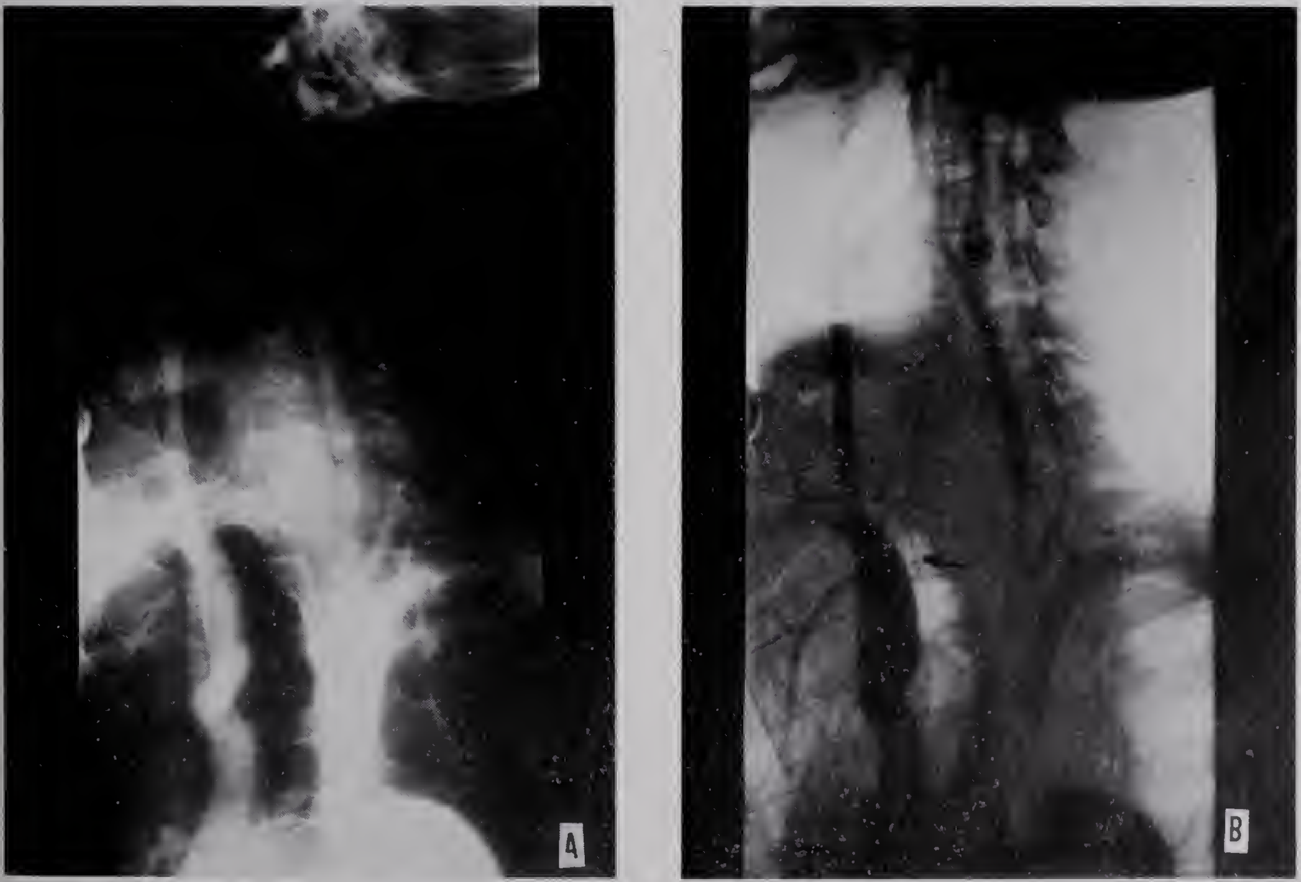

Fig. 2 Case #2. (A) Presubtraction film. Note nonvisualization of right vertebral artery. (B) Subtraction print reveals atretic right vertebral artery *(arrow)* and nonocclusive disease of both carotid bifurcations.

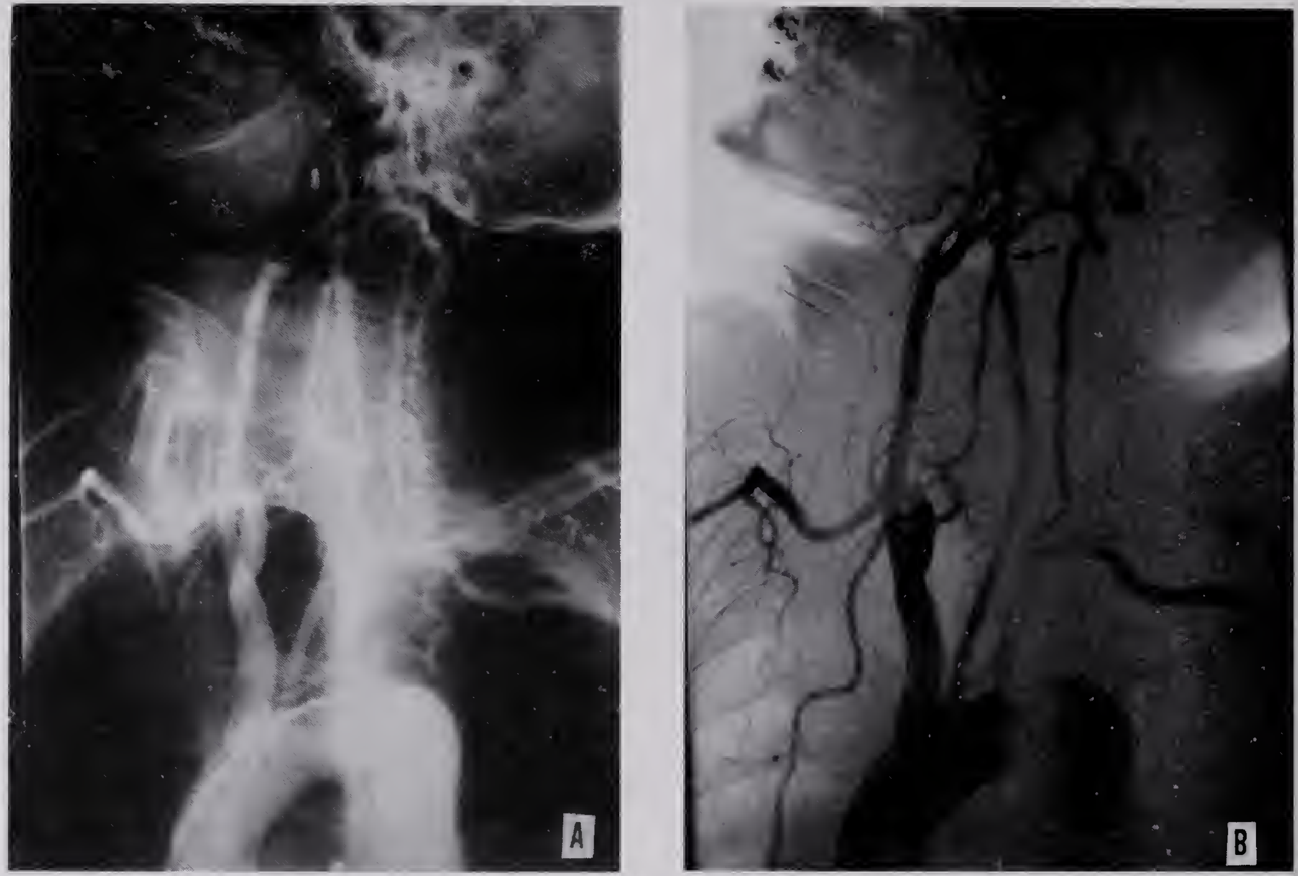

Fig. 3 Case #3. (A) Presubtraction film. Note definite abnormality *(small arrow)* at left carotid bifurcation. (B) Subtraction print demonstrates complete occlusion of the left common carotid artery *(large arrow)* with overlapping of right vertebral artery.

of the subtraction technique in arch aortography. At the University of Missouri-Columbia Medical Center, subtraction is routine for all arch studies and is conducted according to the method described by Joyce *et al.*[4] (An excellent, basic discussion of the subtraction technique is presented by E. E. Christensen, T. S. Curry and J. Nunnally in *An Introduction to the Physics of Radiology,* Lee and Febiger (Philadelphia) 1972, pp. 229-34.)

The subtraction prints are made during the course of the study and require only three additional films over and above the angiographic run. Good quality subtraction studies are possible with very little additional cost of materials and no special equipment in any radiology department doing angiography.

It must be noted that proper patient positioning is essential for these studies. The patient is placed in the right posterior oblique position which is best for "opening" the aortic arch and for visualizing the brachiocephalic vessels. Adequate demonstration of the intracranial circulation, of course, is a prerequisite for corrective surgery.

SUMMARY

Most of the literature on the subtraction technique emphasizes methods[1-9] instead of clinical benefits. A recent article by Hoffman and Rein[10] is the exception. The preceding discussion includes three clinical examples in which a roentgenographic diagnosis was greatly facilitated by subtraction, a technique which is easily within the capabilities of the smaller community hospital's radiology department.

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A Computer-Based Drug Information System

To assist the clinician in making informed therapeutic decisions, a computer-based drug information system is being developed by the Information Science Group and the Medical Computer Center of the University of Missouri School of Medicine in cooperation with the Departments of Pharmacology and Medicine. The system provides a quick, impartial reference source of all drugs, their interactions and basic pharmacologic principles.

Dr. Garten is Assistant Professor, Department of Pharmacology; Dr. Mengel is Professor and Chairman, Department of Medicine; Dr. Stewart is Professor of Pathology and Director, Medical Computer Center; and Dr. Lindberg is Professor of Pathology and Director, Information Science Group at the University of Missouri School of Medicine.

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APPROXIMATELY 15% of all patients entering a hospital today can expect to have an adverse drug reaction that will prolong their hospital stays.[1-4] Another 5% are admitted to hospitals because of adverse drug reactions.[5] As a result, one seventh of all hospital days are devoted to treating drug toxicity at a cost of $3 billion annually.[6]

A factor contributing to this problem is multiple drug therapy.[2, 4, 7, 8] During a typical hospital stay, a patient might be given an average of six to 13 drugs simultaneously. He could even be given as many as 20 simultaneously, in which case he has a 40% chance of an adverse reaction to one or more of the drugs.[9]

HEW's Task Force on Prescription Drugs cites lack of knowledge about basic pharmacologic principles as one of the major defects in the practice of medicine in this country.[6]

The physician then must (1) know the basic pharmacology of the ever-increasing number of drugs and (2) prescribe the best combination when polypharmacy cannot be avoided.

To provide a quick, impartial reference source of all drugs, their interactions and basic pharmacologic principles and to improve the quality of patient care, a Computer-Based Drug Information System is being developed by the Information Science Group and the Medical Computer Center in cooperation with the Departments of Pharmacology and Medicine of the University of Missouri School of Medicine.

The system's data base contains information about drug interactions based on actual clinical and experimental evidence and concise information on therapeutic principles. Data on indications, contraindications, precautions, adverse effects, preparations, dosage, mixture and other factors were abstracted and reformatted from the *AMA Drug Evaluations—1971.*

DEVELOPMENT OF THE DATA BASE

Ideally, a drug information system would provide complete information on all drugs and all known incompatibilities. Lack of time and resources, however, forced realistic priorities in the establishment of the model drug data base.

Actually, a small portion of the total number of drugs included in a hospital pharmacy account for most of the drug traffic. A study conducted at the University of Southern California Medical Center with a pharmacy that annually processes in excess of 550,000 prescriptions revealed that 25 drug products accounted for 50% and 166 drug products accounted for 90% of all prescriptions.[10]

A similar study conducted at the University of Missouri-Columbia Medical Center Pharmacy provided a system of priorities for adding classes of drugs to the data base.

COMPUTER SYSTEM

CONSIDER, an existing storage and retrieval system for formatted text, is used for the Drug Information System. CONSIDER is a general purpose system which has been applied to medical edu-

TITLE

ANABOLIC STEROIDS POTENTIATE ANTICOAGULANT EFFECT

ALTERNATE TERMS

METHANDROSTENOLONE, DIANABOL; NORETHANDROLONE, NILEVAR; NANDROLONE DECANOATE, DECA-DURABOLIN; NANDROLONE PHENPROPIONATE, DURABOLIN.
WARFARIN, COUMADIN SODIUM, PANWARFIN; WARFARIN POTASSIUM, ATHROMBIN-K; BISHYDROXYCOUMARIN, DICUMAROLE.

CLINICAL IMPLICATIONS

ANABOLIC STEROIDS SUCH AS METHANDROSTENOLONE AND NORETHANDROLONE POTENTIATE THE HYPOPROTHROMBINEMIC EFFECT OF COUMARIN ANTICOAGULANTS, ALSO INDANDIONES. THESE STEROIDS DO NOT AFFECT THE DISTRIBUTION OR RATE OF METABOLISM OF ANTICOAGULANTS.
THE USE OF METHANDROSTENOLONE AND NORETHANDROLONE SHOULD BE AVOIDED IN PATIENTS RECEIVING ANTICOAGULANTS FOR IT MAY PRECIPITATE HEMORRHAGIC COMPLICATIONS; IF URGENTLY REQUIRED, LOWER COUMARIN DOSAGE AND CLOSELY FOLLOW PROTHROMBIN TIMES.
MAY ACT SYNERGISTICALLY WITH THE COUMARINS TO DEPRESS HEPATIC SYNTHESIS OF VITAMIN K DEPENDENT CLOTTING FACTORS OR MAY INCREASE THE AFFINITY OF THE RECEPTOR SITE IN THE LIVER FOR THE ANTICOAGULANT.

Fig. 1 The listing of title, alternate terms and clinical implications user would obtain when expanding on the fact entitled "Anabolic Steroids Potentiate Anticoagulant Effect."

cation,[11] medical differential diagnosis,[12] bibliographic,[13, 14] drug information[15] and a number of other kinds of reasonably well-recorded textual information.

CONSIDER deals with English language text which has the hierarchical organization: words, sentences, items, paragraphs, paragraph names, facts, fact names. Words are stored in natural form. Each word is indexed through a set of word-occurrence tables. All Boolean combinations of words are searchable according to their occurrence at any specifiable level in the hierarchy and with the usual truncation capabilities. The system displays counts and names of the records satisfying each Boolean search. The user then determines which full records will be displayed or printed. The software supports up to 20 simultaneous users. The user requires a teletype or cathode ray tube computer terminal. We have successfully used both fixed and portable terminals.

UPDATE SYSTEM

If this system is to become an integral part of the delivery of patient health care, it must be continually updated to assure that the user obtains the most current and critical therapeutic information. The update system allows for easy deletion or expansion of old records (or portions of records) and addition of new records.

Following is a description of the use of the system in a typical clinical situation:

An elderly patient receiving long-term anticoagulant therapy with warfarin (Coumadin) has broken her hip. Her physician feels that an anabolic steroid should be given for the hip to heal properly and to prevent senile osteoporosis. Before adding methandrostenolone (Dianabol) to the patient's therapy, however, he wishes to ascertain whether or not the steroid will interfere with the anticoagulant.

The physician goes to his teletype and after entering preliminary accounting information, types "/NEG," which indicates he wants to enter words. Then, one at a time, he enters the words "Dianabol," "Coumadin," "Interaction" and "Human." It does not matter if the generic name for the anticoagulant or anabolic steroid is used; the same records will be retrieved. Other brand names for the steroid or anticoagulant also could be used. The word "Human" was entered in this example to indicate that the hypothetical physician might be interested in the incompatibility only if there were evidence from observation of humans, not animals. Both kinds of reports are stored in our data base.

If he were uncertain of the spelling of the drug name, he would simply enter the first part of the word followed by three periods, as "Acetamin . . ." for "Acetaminophen."

Next, he enters "/EQU," indicating that he is ready to indicate the logical relationship he desires between the words.

He now forms an equation with the letters assigned to the words he has entered. An asterisk stands for "AND," a plus sign for "OR" and parentheses are used to avoid ambiguity. In this case, the physician wants any record that contains all four words. So, the equation he enters looks like "A*B*C*D" where the letters mean Dianabol, Coumadin, Interaction and Human in that order.

The response indicates that one record satisfies this equation. To see the title he enters "/T." If there had been more than one title, he could have them sorted in alphabetical order by entering "/TITLES, ALPHA." From the title (Anabolic Steroids Potentiate Anticoagulant Effect), he already knows the incompatibility exists and the effect. This may be all the physician wants to know.

If he wants further information, such as if the steroid will interfere with the distribution or rate of metabolism of the anticoagulant, if the combination should be avoided (but, if necessary, what should be done) and possible mechanisms of action, he can expand on the particular record by entering "/EXP," followed by the letter corresponding to the title, "/EXP, AO" (Fig. 1).

He then begins reading the full text of the record starting with the above mentioned clinical implications (after the title and alternate drug names). Following the clinical implications, he may begin to review the experimental evidence for himself (Fig. 2) to decide on the merits of the results presented. If at any time he wants to see the preceding display, he can enter "B." Each separate block of evidence is tagged with the name of the author(s) so that the user can quickly relate it to the reference at the end of the record. Experimental evidence contains such important information as the number of patients, dosages received, length of time they were taken, symptoms that result and other information.

Hence, in a matter of a minute, the clinician has obtained the degree of therapeutic information needed which will help him in reaching a decision about adding the anabolic steroid to the patient's therapy.

The following is another example of a way in which the system could be used:

A patient receiving anticoagulant therapy plus other drugs starts bleeding extensively from her uterine tract. Her prothrombin time has risen above therapeutic levels without any change in anticoagulant dosage. The clinician could use this system by entering the signs, such as bleeding and increased prothrombin time. He would get a list of titles of incompatibilities that are characterized by bleeding tendencies and increased prothrombin time. Then, he can expand the particular record which contains the drug he is using with the anticoagulant. In a matter of a minute, the physician has determined which drug is the causative agent.

The system also will monitor drug profiles. A patient taking Coumadin could also be taking a diuretic such as Hygroton (chlorthalidone), a hypocholesterolemic agent such as Atromid-S (clofibrate), an antianxiety agent such as Librium (chlordiazepoxide), a mild analgesic such as Tempra (acetaminophen) and several other drugs. When an incompatibility is found, a printout of the material on the incompatibilities will be sent to the prescribing physician. Thus, within the first days after starting therapy, the physician is warned

EXPERIMENTAL EVIDENCE

10 PATIENTS WITH CORONARY HEART DISEASE WERE WELL STABILIZED ON MAINTENANCE THERAPY WITH WARFARIN (7) OR PHENINDIONE (3). THEY WERE GIVEN METHANDROSTENOLONE 10 MG DAILY FOR 14 DAYS. AN INCREASED SENSITIVITY TO WARFARIN BECAME EVIDENT IN ALL CASES DURING METHANDROSTENOLONE THERAPY.

THE DOSAGE OF WARFARIN REQUIRED TO MAINTAIN THE PP VALUES WITHIN THERAPEUTIC RANGE WERE SIGNIFICANTLY REDUCED. AFTER STOPPING METHANDROSTENOLONE THE ANTICOAGULANT REQUIREMENTS ROSE WITHIN A WEEK TO THE SAME LEVEL AS BEFORE THE ANABOLIC STEROID. (PYORALA AND KEKKI)

THE RESPONSE TO SINGLE DOSE OF 20 MG OF WARFARIN IN HEALTHY SUBJECTS (8) WAS FOUND TO BE INCREASED WHEN THEY TOOK METHANDROSTENOLONE 10 MG DAILY FOR 10 DAYS (PYORALA AND KEKKI).

SIMILAR RESULTS WERE REPORTED IN 7 MALE VOLUNTEERS TAKING 10 MG OF NORETHANDROLONE DAILY FOR 2 WEEKS. ON THE 10TH DAY, DICUMAROL WAS ADMINISTERED (100 OR 150 MG). THERE WAS NO CHANGE IN THE HALF-LIFE OF DICUMAROL OR THE ACTIVITY OF THE VITAMIN K-DEPENDENT CLOTTING FACTORS (THROMBOTEST). (SOLOMON AND SCHROGIE). AN ADDITIONAL STUDY WITH 2 PATIENTS ON METHANDROSTENOLONE GIVEN WARFARIN SHOWED A MARKED POTENTIATION OF ANTICOAGULANT EFFECT EVEN WHEN VITAMIN K1 WAS ADMINISTERED (DRESDALE AND HAYES).

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Fig. 2 The listing of experimental evidence and references user would obtain when expanding on the fact entitled "Anabolic Steroids Potentiate Anticoagulant Effect."

of possible adverse reactions due to the combined drug action.

If the physician wants information on a basic therapeutic principle, he enters the name of the drug (either the generic or one of the more popular brand names) plus the abbreviation for the principle. For example, Coumadin, "CTR" (contraindications) or Digoxin, "CAU" (precaution). He promptly receives that particular item of information without paging through unwanted material.

USE OF THE DRUG INFORMATION SYSTEM FOR TEACHING

The Drug Information System is being integrated into the medical pharmacology course taught to second-year students at the University of Missouri Medical School. Students learn how to use the system quickly. As they encounter a new class of drugs, they go to the data base and review possible incompatibilities that could occur.

Terminals are being located conveniently for students and inhouse staff to easily access the data base.

A clinical advisory group composed of Medical Center staff and, also, physicians in private practice are using the system and suggesting possible improvements.

Continuing education programs are being planned to acquaint clinicians with the system.

We would appreciate evaluation by readers concerning the potential value of the computer-based drug information system and their recommendations regarding which drug areas ought to be developed next. We also need to learn of the readers' experiences with unexpected drug interactions.

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The post-T&A patient: another type for Tylenol (acetaminophen)

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

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Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Elixir, 120 mg./5cc. (alcohol 7%).
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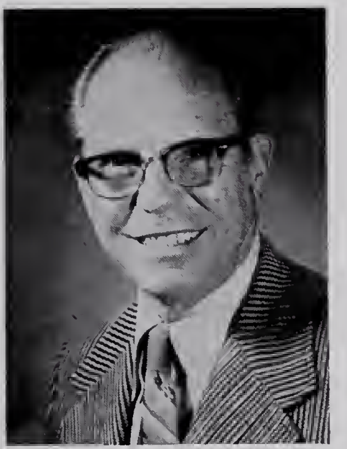
President's Message

Most MSMA members are fully aware of the many important national issues which would affect the practice of medicine—PSRO, national health insurance, FDA regulations and others. But, many of us fail to realize that we are faced with many similar problems on the state level each time the Missouri General Assembly convenes.

When the voters of Missouri approved Annual Sessions of the Legislature a few years ago, every association in the state knew its work load would increase. However, few realized the extent to which Annual Sessions would affect the day-to-day routine of Associations such as the MSMA.



E. A. Stricker, M.D.

When the General Assembly met every other year, there was a "breathing spell" to recoup and get back to regular Association duties.

However, when you examine the regular reports of the MSMA Legislative Committee, it is evident that Annual Sessions doomed the "breathing spell" and when work is completed on one Session, it is time to begin concentrating on the next Session.

The current Second Session of the 77th General Assembly is a good example. This is the "Short Session" scheduled to run four months compared to the six-month Session during odd-numbered years.

But, "Short Session" means very little when you realize that more than 100 medically-related bills have been introduced in the General Assembly. That is only a few less than were introduced in the 1973 six-month Session.

The work carried out by our Legislative Committee and by the physicians from around the state who volunteer their time and expertise by presenting testimony before hearing committees is invaluable indeed to all who practice medicine in Missouri.

Equally as important are the "key physicians" in the various political divisions of Missouri. These physicians are kept informed on state legislation and contact their elected representatives to insure that medicine's point of view is expressed. Of course, the more "key physicians" we have, the better our story can be told!

If you have wondered what you can do for medicine, consider becoming a "key physician." Contact the Legislative Committee at MSMA Headquarters for further information.

And remember! For the time it takes to place a telephone call or write a letter, you can contribute appreciably to the voice of medicine in Missouri.

Must vasodilators and therapy for other diseases come into conflict?

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25:*134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Woman's Auxiliary

50th Anniversary

While preparing the files and records for my successor as President of the Woman's Auxiliary to the MSMA, I was reminded again and again that there is so much yet to be accomplished.

Fifty years ago, a small group of physicians' wives with vision and courage founded the Woman's Auxiliary to the MSMA with three basic goals: (1) to assist the Missouri State Medical Association, (2) to advise the county medical society auxiliaries and coordinate their efforts, and (3) to cultivate friendly relations and promote mutual understanding among the physicians' families.

One year ago, it became my privilege and responsibility to carry on the work handled so well by my predecessors. However, regardless of how much had been accomplished in the previous years, two questions remained, *"What more can we do? How can the Auxiliary be more effective?"* Steeped in the conviction that we can do more if united and that we will be successful through strength, I earnestly plead that we heed all efforts in the years to come for unity, strength and effectiveness. With a purpose, these should be our goals.

One official survey of physicians has revealed that improved communications and public relations are among their top priorities. With this in mind, just imagine what an important public relations job we can do if every eligible physician's wife joins our ranks.

Mrs. Charles R. Willman
President

Unity will be the name of the game in the coming year as we put it all together for good health.

One of the great challenges of these changing times is for physicians and their wives to help solve the health problems of our country. With this thought in mind, I ask that, on both the county and state levels, we all continue our efforts toward membership and quality programs in the organizations to which we belong.

I am grateful for the opportunity I have had to work with the Association and the Staff and for being allowed to represent your Association in the Auxiliary with honor. It has been a responsibility filled with pleasure.

EDITORIAL

BUILT-IN ORDERLY ORGANIZED KNOWLEDGE SYSTEM

A new aid to rapid learning has made its appearance. This device is known as "Built-in Orderly Organized Knowledge System." It has many advantages over the old style learning and teaching aids. There are no wires, it needs no electricity, it is made entirely without any mechanical parts to go wrong or to need replacement.

Basically, this device consists only of a number of paper sheets. These may run to several hundred if there is a lengthy program of information to be covered. Each sheet bears a number in sequence and is held in the proper order by a special locking device called a binding.

Each sheet of paper presents the user with an information sequence in the form of symbols which he absorbs optically for automatic registration on the brain. When one sheet has been assimilated, a flick of the finger turns it over and further information is found on the other side.

By using both sides of the sheet in this way great economy is effected, thus reducing both size and cost. No buttons need to be pressed to move from one sheet to another or to start it working. The user may turn at will to any sheet, going backward or forward as he pleases. A location finder is provided near the front for any required information sequence.

A series of these devices may be stored on handy shelves, and for ease of reference, the exact program schedule is generally indicated on the back of the binding. Once purchased there is no further upkeep cost, for the motive power is supplied by the brain of the user. There is, however, a small accessory available at trifling extra cost known as a "bookmark." This enables the user to pick up his program where he left off at a previous learning session.

The maker is allowed to copyright and sell this system under its generic name which is actually an acronym for "Built-in Orderly Organized Knowledge." Altogether, it seems to have great advantages and no drawbacks. We predict a big future for BOOKS.

Reprinted from the *Journal of Iowa Medical Society*
August, 1973
Original Author is unknown

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County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

Fifty-two members and guests attended the March 6 dinner meeting and program at the Moila Club in St. Joseph. The speaker for the event was Dr. Duane L. Larson, chief-of-staff of the Shriner's Hospital for Crippled Children Burn Institute in Galveston, Tex. He discussed "Care of the Burn Patient."

Dr. Larson has received several awards in recognition of his work in research, care and rehabilitation of burn patients. In 1959, he was awarded the commendation ribbon with medal pendant from the U. S. Army Medical Corps for research in the field of thermal injuries. In 1971, he served as president of the North American Burn section of the Pan-American Medical Association. That same year, he was awarded the Governor's annual physician's award for the state of Texas. In 1972, he received the annual physician's award from the President of the United States in recognition of his accomplishments in rehabilitation of burn patients.

Dr. Larson was introduced by Dr. Edward H. Andres, a member of the Society's program committee, who served with Dr. Larson at the Brooke Army Hospital in Texas.

Dr. Randal W. Weed presided at the meeting and business session.

John T. Rogers, M.D., *Secretary*

Grand River Medical Society

The Grand River Medical Society and the Woman's Auxiliary met at the Strand Hotel in Chillicothe on February 14. Eleven members and their wives were present.

Guest speaker was William A. Leo, M.D. of Kansas City who spoke on "Breast Masses."

There was a short business meeting. Delegates to the MSMA Annual Session and their alternates were nominated. It was voted to donate a sum of $200 to the Missouri State Medical Foundation. Dr. Dowell is to present the check at the annual meeting in April.

It was voted that the Grand River Medical Society participate with Buchanan County and Clay County medical societies in providing a hospitality room at the MSMA Annual Session.

George Mandler, M.D., *Secretary*

SECOND DISTRICT

COUNCILOR
LYSLE M. BACH, M.D., HANNIBAL

Chariton-Macon-Monroe-Randolph County Medical Society

The Chariton-Macon-Monroe-Randolph County Medical Society held its February meeting at Woodland Hospital in Moberly on February 14.

Guests for the Valentine Day meeting were the wives of the members.

The speaker for the evening was Dr. E. A. Stricker of St. James, President of the Missouri State Medical Association. Dr. Stricker discussed the many benefits of being a member of the MSMA and the importance of the Association keeping its members informed of events in the health care field.

Dr. Stricker was accompanied by Mr. Raymond McIntyre, Jefferson City, Executive Secretary of the MSMA, who discussed bills of interest to the medical profession that are now before the Legislature.

Dr. James E. Campbell of Macon, President of the Society, presided at the meeting. Those who attended the meeting are Dr. and Mrs. Stricker; Mr. and Mrs. McIntyre; Dr. and Mrs. Campbell; Dr. and Mrs. F. A. Barnett of Paris; Dr. and Mrs. F. L. Harms, Salisbury; Dr. P. V. Dreyer, Huntsville; and Dr. and Mrs. Robert H. Young, Dr. and Mrs. C. C. Cohrs, Dr. and Mrs. Robert V. Tompson, Mrs. J. W. Fleming, Dr. Josephine Baker, Dr. and Mrs. G. R. Hudson, Dr. T. S. Fleming and Dr. W. D. Chute, all of Moberly.

R. V. Tompson, M.D., *Secretary*

NINTH DISTRICT

COUNCILOR
CLAUDE W. COOPER, M.D., THAYER

Mid-Missouri County Medical Society

The Mid-Missouri Medical Society met at the Tower Inn in Salem on February 9. The meeting was called to order by the chairman, Dr. Barbara Russell.

Dr. Billy J. Bass moved that Drs. Barbara E. Russell, E. A. Stricker and Bernard Draper contact doctors in various counties to serve on a membership committee. Dr. F. M. Elders seconded the motion. The motion was passed.

Dr. Bass moved that the Society sponsor a hospitality suite at the MSMA Annual Session. An assessment on members may be made, if necessary, to pay the expense. South Central, the other medical society in the Ninth Councilor District, was invited to participate in sponsorship. Dr. Elders seconded the motion. The motion was passed.

Delegates were selected for the MSMA Annual Session as follows: Drs. Bass, Dent County; F. M. Elders, Crawford County; Earl E. Feind, Maries County; Barbara E. Russell, Phelps County; Clyde S. Miller, Pulaski County; and R. W. Froelich, Laclede County.

Alternates are Dr. R. E. Mitchell and Dr. Dennis F. Hite.

Thirty-one members and guests attended the meeting. The Honorable Richard Ichord spoke on medical legislation before Congress, his responsibilities in Congress and his recent trip to the Middle East.

Bernard Draper, M.D., *Secretary*

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D., POPLAR BLUFF

Mineral Area County Medical Society

The Mineral Area County Medical Society met at the Hoctor Building at the Farmington State Hospital in Farmington on January 31. The meeting was well attended.

Members present viewed a film on gastrointestinal disease and heard a discussion of direct visualization of the epigastrointestinal tract through special new optical equipment now available in some of the local hospitals. The presentation was made by Drs. Oliver and Hoye.

At the business meeting which followed, members approved several resolutions that deal with matters which directly affect the health care of people living in Southeast Missouri. The resolutions will be introduced at the 116th Annual Session of the Missouri State Medical Association.

Delegates to the Annual Session of the MSMA were elected. Delegates are Drs. Norma Farmer, C. W. Chastain, Metin Arat, Robert Dettmer, Carlos Borromeo and A. G. Karraker. Alternate Delegates are Drs. Marvin Menne, Jack Mullen, A. R. Rao, Paul Dennis and T. R. Burcham.

It was announced that there will be a meeting of the Medical Society with the lawyers of this judicial circuit on March 8.

Members and guests at the meeting included President Norma Farmer; Vice-President Metin Arat; Secretary-Treasurer C. W. Chastain; and Drs. Karraker, Arthur D. Newcomb, F. Richard Crouch, Hoye, Juan Cancelada, Oliver, Borromeo, Javier A. Pichardo, Emmett F. Hoctor, Tan, Menne, Charles H. Appleberry, Dettmer, Robert A. Huckstep, N. K. Datta, Jay F. Tuttle and Minkovich.

Guests were Mr. Bruce Pegram, a fourth-year medical student at the University of Missouri; John Johnson of Merrell Laboratories; and Edward Klein of Medical Arts Pharmacy.

Charles W. Chastain, M.D., *Secretary*

Continuing Education Coming Events

(Continued from page 170)

April 27	**Day of Clinical Radiology** Continuing Education M.U. Medical Center, Columbia
May 2-4	**Symposium: Physical Fitness** M.U.-Kansas City School of Medicine and Kansas City Southwest Clinical Society Crown Center Hotel
May 13-16	**Symposium: Basic Electrocardiography** Postgraduate Medical Education K.U. School of Medicine, Kansas City, Kan.

New Members

Frederick Bauschard, M.D., 7157 Pershing, St. Louis, has become a member of St. Louis Medical Society. Dr. Bauschard is a native of New York, received his preliminary education at Allegheny College and his M.D. degree at the University of Pittsburgh in 1968. He specializes in dermatology.

Clyde L. Brower, M.D., 1515 W. Truman Rd., Independence, has become a member of Jackson County Society. Dr. Brower is a native of Kansas City, received his preliminary education at William Jewell College and his M.D. degree at the University of Kansas in 1944. He is in the general practice of medicine.

Arsenio L. Canlas, M.D., 2415 N. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Canlas is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1953. He is a surgical assistant.

Michael P. Chouinard, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Chouinard is a native of Illinois, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1966. He specializes in internal medicine.

Sanford Cobb, M.D., 10236 Bunker Ridge Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Cobb is a native of Boston, Mass., received his preliminary education at Trinity College and his M.D. degree at Albany Medical College in 1951. He specializes in pharmaceutical medicine.

Thomas F. Craven, M.D., 7111 Cornell, St. Louis, has become a member of St. Louis Medical Society. Dr. Craven is a native of North Dakota, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1970. He specializes in radiology.

George H. Dowell, M.D., 2821 N. Ballas Rd., St. Louis, has become a member of St. Louis County Medical Society. Dr. Dowell is a native of Baltimore, Md., received his preliminary education at Amherst College and his M.D. degree at Washington University in 1969. He specializes in psychiatry.

Ann F. Goerz, M.D., 1612 W. Truman Rd., Independence, has become a member of Jackson County Medical Society. Dr. Goerz is a native of Springfield, received her preliminary education at the University of South Dakota and her M.D. degree at Tulane University in 1965. She specializes in pediatrics.

Walter Ford Keitzer, M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. Keitzer is a native of Logansport, Ind., received his preliminary education at the University of Michigan and his M.D. degree at the University of Michigan in 1956. He specializes in surgery.

Kaye H. Kilburn, M.D., VA Hospital, Columbia, has become a member of Boone County Medical Society. Dr. Kilburn is a native of Logan, Utah, received his preliminary education at the University of Utah and his M.D. degree at the University of Utah in 1954. He specializes in internal medicine (pulmonary disease).

Thomas F. Martin, M.D., 3165 Myrtle, Granite City, Ill., has become a member of St. Louis Medical Society. Dr. Martin is a native of Texas, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1965. He specializes in cardiology.

Laureano G. Mayuga, M.D., 526 Spruce, Cabool, has become a member of South Central County Medical Society. Dr. Mayuga is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1963. He specializes in surgery.

G. Leland Melson, M.D., 510 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Melson is a native of Nebraska, received his preliminary education at Ottawa University and his M.D. degree at Washington University in 1965. He specializes in radiology.

Mande D. Monta, M.D., Methodist Medical Center, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Monta is a native of the Philippines and received his M.D. degree at the University of Santo Thomas in 1960. He specializes in pathology.

Joseph E. Montie, M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. Montie is a native of Detroit, Mich., received his preliminary education at Michigan University and his M.D. degree at Wayne State University in 1965. He specializes in urology.

Gary L. Pack, M.D., 751 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Pack is a native of Winfield, Kan., received his preliminary education at Kansas State University and his M.D. degree at the University of Kansas in 1967. He specializes in neurology.

Paul V. Paul, M.D., 1755 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Paul is a native of India, received his preliminary education at S.B. College and his M.D. degree at Christian Medical College in 1965. He specializes in surgery.

Thomas John Prendergast, Jr., M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. Prendergast is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at Washington University in 1966. He specializes in preventive medicine—epidemiology.

In Memoriam

Jack I. Kenzler, M.D., 819 Locust, St. Louis, a graduate of the University of Indiana, 1953; member of St. Louis County Medical Society; age 47; died Jan. 12, 1974.

John J. Davis, M.D., 9011 Delmar, Overland Park, Kan., a graduate of the University Medical College, 1911; member of Jackson County Medical Society; age 93; died Feb. 13, 1974.

Raymond A. Stansbrough, M.D., 7520 Natural Bridge Rd., Normandy, a graduate of St. Louis University, 1953; member of St. Louis Medical Society; age 51; died Feb. 18, 1974.

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PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

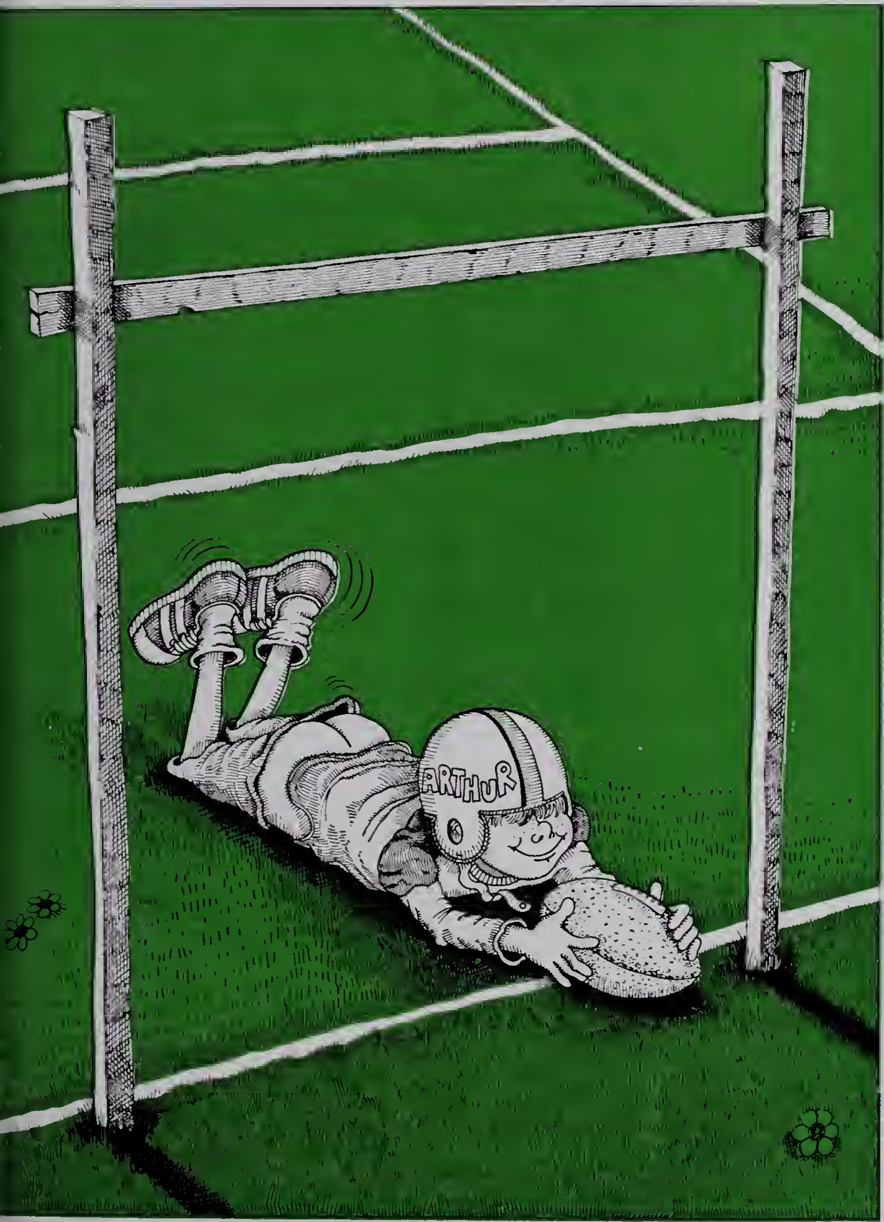
WORMS BLITZED

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



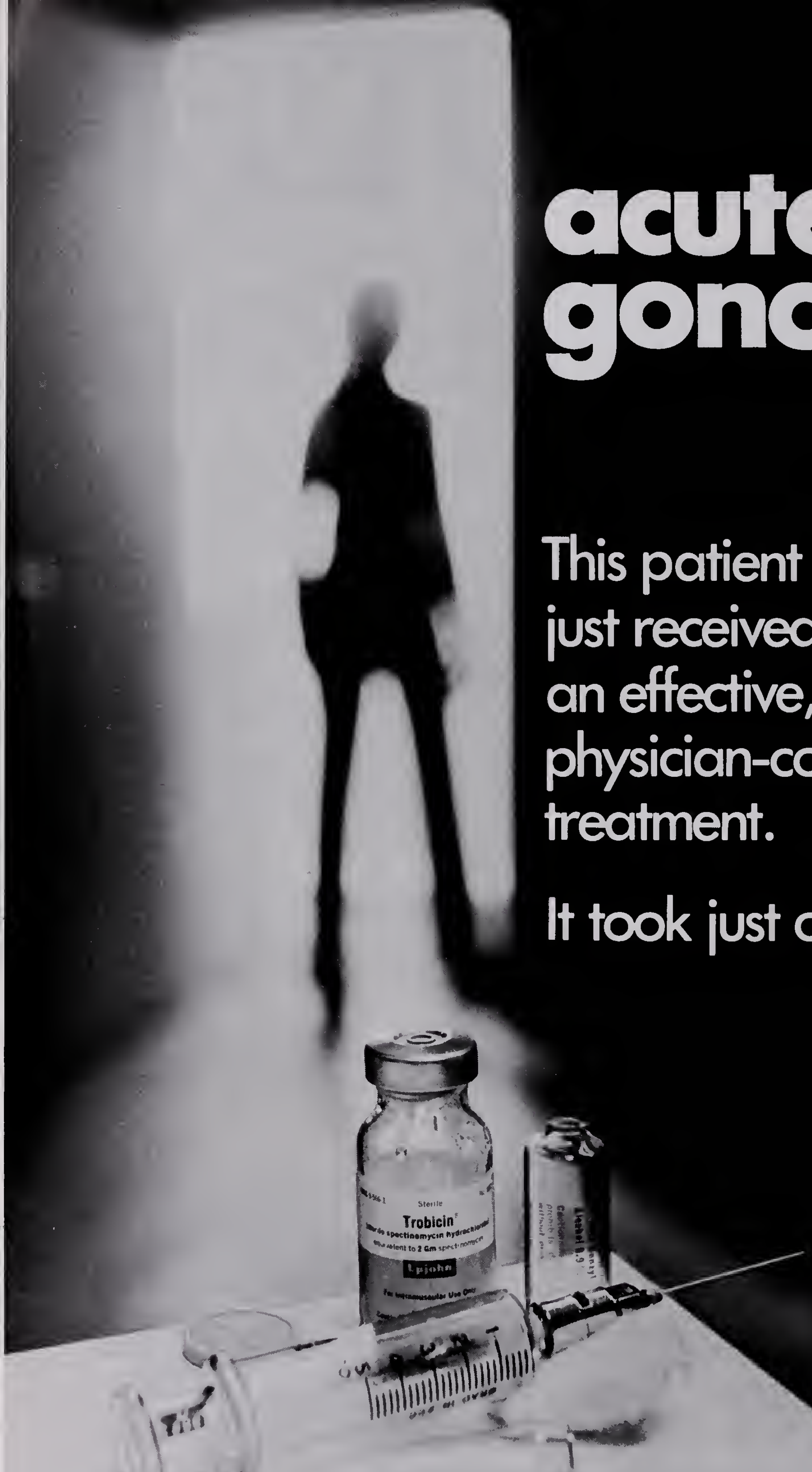
Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®
(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.
ORAL SUSPENSION

Data on file at Roerig.

Please see prescribing information on facing page.


Sterile
Trobicin
spectinomycin hydrochloride
equivalent to 2 Gm spectinomycin
Upjohn
For Intramuscular Use Only

acute gonorrhea

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit…

*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

973 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly[†]; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

..and **Trobicin**® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

erile Trobicin
erile Trobicin (spectinomycin hydrochloride) For Intramuscular Injection:

gm vials containing 5 ml when reconstituted th diluent.

gm vials containing 10 ml when reconstituted th diluent.

aminacyclitol antibiotic active *in vitro* against ost strains of *Neisseria gonorrhoeae* (MIC 7.5 20 mcg/ml). Definitive *in vitro* studies have own no cross resistance of *N. gonorrhoeae* tween spectinomycin and penicillin.

dications: Acute gonorrheal urethritis d proctitis in the male and acute gonorrheal rvicitis and proctitis in the female when due susceptible strains of *N. gonorrhoeae*.

ontraindications: Contraindicated in pa- nts previously found hypersensitive to spec- amycin.

arnings: Not indicated for the treatment of philis. Antibiotics used to treat gonorrhea ay mask or delay the symptoms of incubating philis. Patients should be carefully examined d monthly serological follow-up for at least months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Caution: Federal law prohibits dispensing without prescription.

For additional product information see your Upjohn representative or consult the package insert.

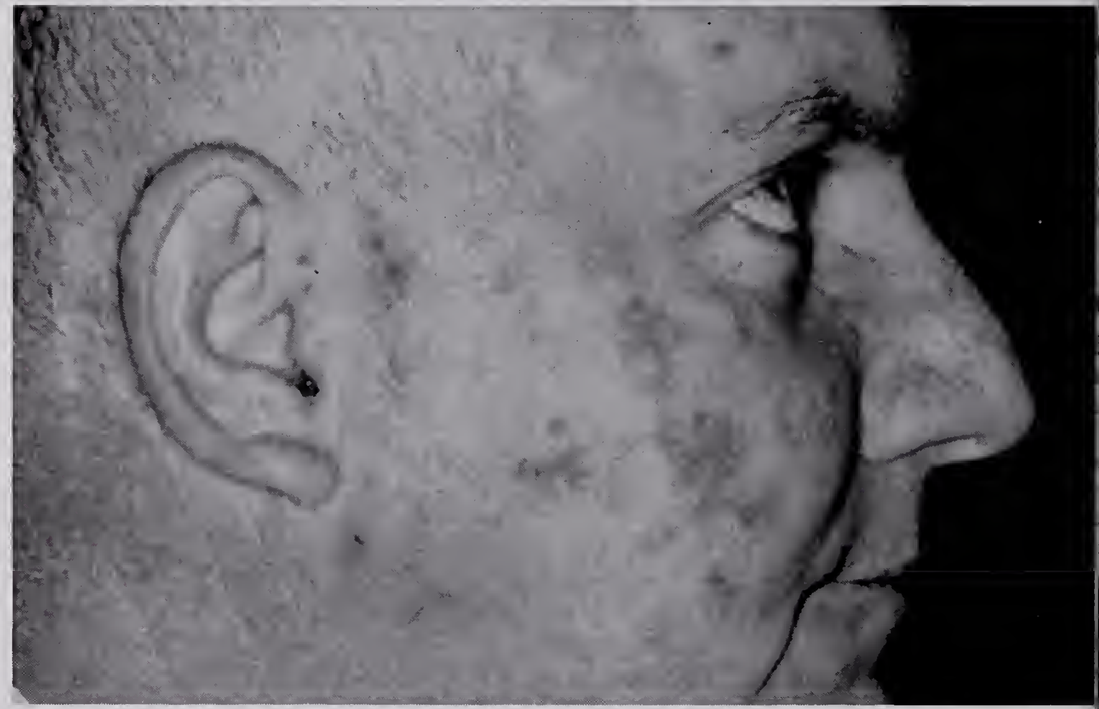
Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

[†] For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic esistance is known to be prevalent, initial treatment with 4 grams is preferred.

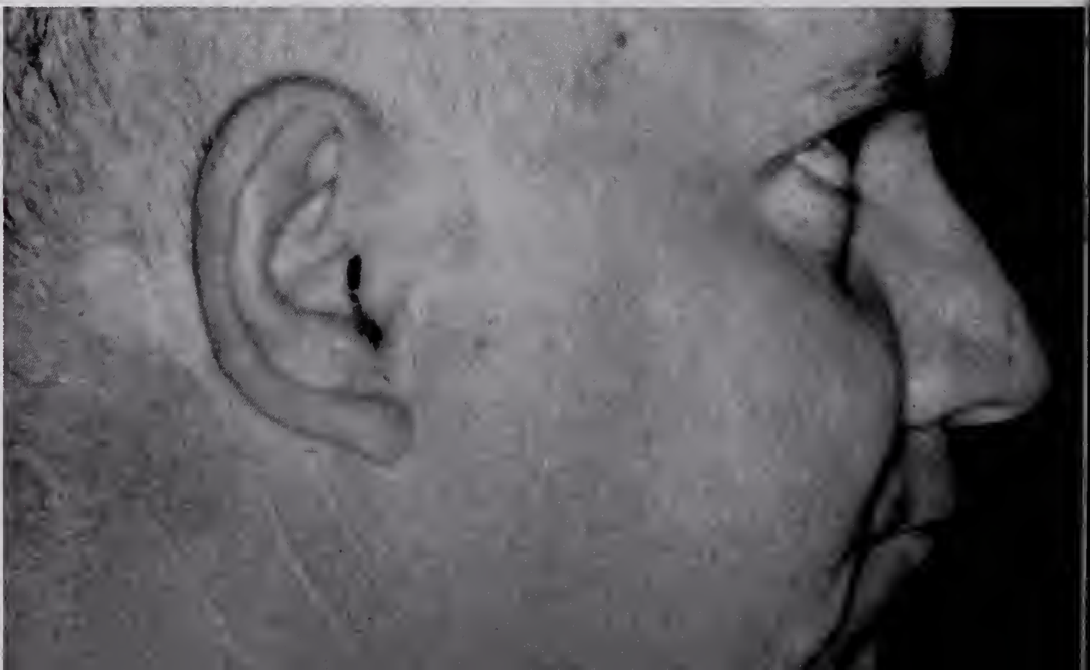
What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.



*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

he lesions on his face re solar/actinic– o-called "senile" keratoses... nd they may be premalignant.

olar, actinic or senile keratoses

hese lesions may be called by several names, but they ually can be identified by the following characteris- s. The typical lesion is flat or slightly elevated, of a ownish or reddish color, papular, dry, rough, adherent d sharply defined. They commonly occur as multiple sions, chiefly on the exposed portions of the skin.

equence of therapy– electivity of response

fter several days of therapy with Efudex® (fluorouracil), ythema may begin to appear in the area of the lesions; is reaction usually reaches its height of unsightliness d discomfort within two weeks, declining after dis- ntinuation of therapy. This reaction occurs in affected eas. Since the response is so predictable, lesions that not respond should be biopsied.

cceptable results

eatment with Efudex provides highly favorable cos- tic results. Incidence of scarring is low. This is par- ularly important with multiple facial lesions. Efudex ould be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local–pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported–insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers–containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes–containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

ROCHE

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Nutley, N.J. 07110

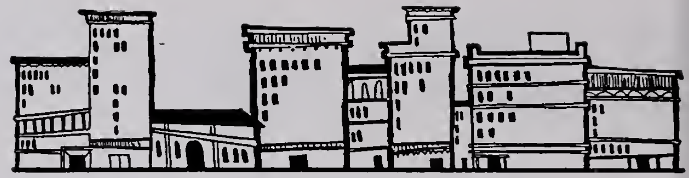
his patient's lesions were resolved with

Efudex®

fluorouracil/Roche®

5% cream/solution...a Roche exclusive

From the Medical Schools



WASHINGTON UNIVERSITY

The National Cancer Institute has awarded $62,239 to a Washington University School of Medicine radiologist to evaluate new cancer treatment techniques with fewer side effects.

Carlos A. Perez, M.D., professor of radiology, will direct the investigation in the Medical Center's Mallinckrodt Institute of Radiology's Division of Radiation Oncology. The study will involve the treatment of persons with cancers of the brain, head, lung, neck and rectum. Patient information will be combined with that from 40 other university hospitals participating in the National Cancer Institute's Radiation Therapy Oncology Group.

More than 100 cancer patients from the St. Louis facility will be analyzed in the cooperative clinical effort. Treatment will be by surgery, radiation, chemotherapy—or a combination of the three. The grant will be used to supplement patient care expenses and to pay salaries of professional staff.

The Deafness Research Foundation has awarded $10,000 to the School of Medicine for students on diseases of the ear.

Gershon J. Spector, M.D., assistant professor of otolaryngology, will use the grant to direct a project on "A clinical pathologic study of the relation between cytomegalovirus (salivary gland virus) and congenital deafness." Dr. Spector said that it has been demonstrated that these viruses can be transmitted from mother to child and are bloodborn. As a result, they affect many vital structures in the fetus.

ST. LOUIS UNIVERSITY

Two noted lecturers were scheduled to speak at the St. Louis University Medical Center during March.

Dr. John K. Vyden, assistant professor of medicine, University of California Los Angeles School of Medicine, and associate cardiologist, Cedars-Sinai Medical Center and Director of the Peripheral Vascular Laboratory, was a visiting cardiologist. His visit to the St. Louis University Hospitals and School of Medicine was hosted by *Dr. J. Gerard Mudd,* associate professor of internal medicine, and director of the Cardiac Catheterization Laboratory and acting director of the Section of Cardiology.

Dr. Vyden delivered a special lecture titled "Analysis of Electrocardiographic Problems" and conducted grand rounds on "New Concepts in Myocardial Infarction." He also toured the twin cardiac catheterization laboratory facilities at the St. Louis University Hospitals.

Dr. Horsley Gantt, Director of Pavlovian Laboratory, Johns Hopkins Medical School, was the visiting lecturer of the day for the Department of Psychiatry, which is directed by *Dr. Edward T. Auer.* Dr. Gantt has spent some time in Russia.

The dedication of the Cardiac Catheterization Laboratory at St. Louis Veterans Administration Hospital was held on February 20. Main dedication speaker was *William H. Danforth,* Chancellor, Washington University. *Dr. Ralph L. Biddy,* assistant dean for Veterans Affairs for the St. Louis University School of Medicine, and chief-of-staff, VA, and *Dr. Robert H. Felix,* dean, St. Louis University School of Medicine, were among the speakers at the dedication.

UNIVERSITY OF MISSOURI-COLUMBIA

In recognition of excellence in teaching, four University Medical Center professors and a member of the resident housestaff were honored on March 5 at the School of Medicine's spring honors convocation.

Golden Apple awards went to *Dr. Daniel Overack* in the Department of Anatomy, selected by the first-year students; *Drs. Wallace Rogers* and *Michael Hart,* pathologists, chosen by the second-year students; and *Dr. John L. Winnacker,* endocrinologist in the Department of Medicine, voted by third- and fourth-year students as the outstanding clinical teacher.

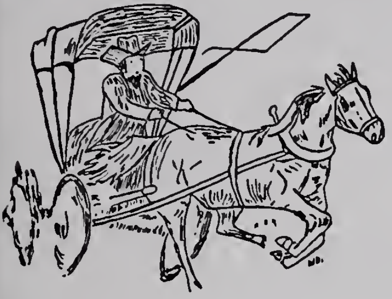
Dr. Terry Grebe, a first-year resident in the Department of Obstetrics and Gynecology, was selected as the outstanding housestaff teacher.

"The Speech Clinician and the Hearing-Impaired Child," a recently-published book, has been edited by *Robert L. Cozad,* Ph.D., chief of audiology at the Medical Center. It contains articles by several current and former UMC professors.

Among the contributors in addition to Dr. Cozad, who also is an associate professor in the Division of Otolaryngology at UMC, are *Dr. Donald J. Joseph,* chief of the section; *Jane B. Seaton* and *Dr. Lester E. Wolcott,* former faculty members at UMC.

LEO H. POLLOCK, M.D.

Missouri Medicine in Review



FORTY YEARS AGO

The Menorah Hospital in Kansas City recently received a gift of $25,000 from Mr. Edgar L. Berkley. The gift was made in memory of the donor's parents, Mrs. Nana Berkley and Mr. Maurice Berkley, one of the founders of the institution.

This year, the *Annals of Surgery* will complete 30 consecutive years as a surgical publication. When Dr. Lewis Stephen Pilcher, New York, advocated the establishment of the *Annals of Surgery,* he probably did not expect to hold the editorial chair continuously for the next 50 years. However, the consummation of such service has been realized this year and the publisher, the J. B. Lippincott Company, is celebrating the journal's half-century of existence and progress under Dr. Pilcher's guidance.

The 77th Annual Session of the Missouri State Medical Association will convene in St. Joseph on May 7-10. St. Joseph physicians are working diligently to make this a successful meeting and plans, which are nearing completion, indicate that the Session will meet their hopes and expectations.

TWENTY-FIVE YEARS AGO

A meeting of representatives from all state medical associations took place at the American Medical Association headquarters in Chicago on February 12. Carl F. Vohs, M.D., St. Louis, and the Executive Secretary attended the meeting. The public relations firm of Whitaker and Baxter outlined the plan for a campaign which is to be followed in order to educate the people in regard to the advantages of the present system of voluntary medical care as compared to compulsory methods. It was pointed out that this is an affirmative campaign. An all-out effort is to be made to enroll the people in sound voluntary health insurance systems. This is to be a broad public campaign with leaders from every walk of life participating. It is not just a doctors' campaign.

Mark M. Marks, M.D., Kansas City, appeared as guest speaker before high school students and a woman's organization in Odessa on February 16. His subject was "Voluntary vs Compulsory Health Insurance." He also spoke on this subject before a civic group in Higginsville in the evening.

C. M. Waugh, M.D. and J. M. Davis, M.D., Tarkio, were recipients of the Tarkio Rotary Club's Buck-of-the-Month award on February 1. The awards were given "for faithful and meritorious service to our community."

TEN YEARS AGO

Ian M. Thompson, M.D., Columbia, participated in a panel discussion at a meeting of the American College of Surgeons in Denver on February 17.

Dr. Henry Sweets of Hannibal was the speaker at the January meeting of the Turner PTA in that community.

The 15th Annual Dr. F. G. Thompson, Sr., Lecture will be given by James C. White, M.D. of Boston, on May 6 at the Thompson, Brumm & Knepper Clinic Building in St. Joseph.

Twenty-eight doctors and wives attended the February meeting of the West Central Missouri Medical Society at the Country Club in Nevada on February 13. After a social hour and dinner, a scientific program was presented by N. K. Mitra, M.D. of Hickman Mills.

More than 40 people, including doctors and guests, attended a dinner meeting of the Lincoln-St. Charles County Medical Society at the Charlevoix Nursing Home in St. Charles on February 25. The evening's festivities began with a tour of this splendid nursing home. There also was a social hour and dinner.

A dinner meeting of the Mid-Missouri County Medical Society and the doctors' wives was held in the new Colonial Village in Rolla on February 27. The scientific speaker for the evening was William G. Hemenway, M.D., Director of the Department of Ear, Nose and Throat at the University of Missouri School of Medicine.

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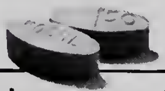

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Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—**Inject 5 ml intramuscularly** for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—**Inject 10 ml intramuscularly** for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

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or patients with gonorrheal proctitis and for patients in geographic areas where antibiotic sistance is known to be prevalent, initial treatment with 4 grams is preferred.

SAM CULLISON, J. CHRISTOPHER REID, Ph.D. ***and***
JACK M. COLWILL, M.D., ***Columbia***

Graduates of the University of Missouri-Columbia School of Medicine

1957-1973

ALTHOUGH THE UNIVERSITY OF MISSOURI-Columbia School of Medicine (UMC) had its origins a century ago, its current four-year program leading to the M.D. degree is relatively recent. The clinical program was initiated in 1955 and the first M.D. degrees were granted in 1957.

In the ensuing 18 years, there has been a progressive increase in the number of graduates. In 1957, 23 M.D. degrees were conferred. This increased to 99 in 1973 and is expected to increase to 110 graduates in 1975.

This paper provides information taken from the first organized review of the graduates of the four-year curriculum. In the spring of 1973, a questionnaire was sent to each of those 1,146 who graduated between 1957 and 1973. Among the questions we sought to answer were the following:

1. What are UMC graduates doing?
2. What specialties have they selected?
3. Where are they located?
4. What factors predicted practice location?
5. Where do recent graduates plan to practice?

TABLE 1

RESPONSE DISTRIBUTION BY CLASS

Class of Graduation	*Size of Class*	*Questionnaires Returned Per Class*	*% Questionnaires Returned*
1957	23	18	78
1958	33	23	70
1959	30	25	83
1960	59	42	71
1961	62	54	87
1962	65	49	75
1963	66	58	88
1964	63	41	65
1965	80	66	80
1966	73	52	71
1967	76	62	82
1968	74	60	81
1969	84	65	77
1970	76	48	63
1971	85	57	67
1972	98	64	65
1973	99	65	66
No Class listed		6	
Total	1,146	855	75

The current study represents a response from 855 physicians or 75% of the total. Table 1 lists the number of graduates by year, the number responding to the questionnaire and the percentage response by the class of graduation. The response from individual classes varied from 63% to 88%. In interpreting the data, we have found little evidence to suggest that the respondents represented a biased sample.

WHAT ARE M.U. GRADUATES DOING?

Fifty-five per cent of the graduates are permanently established in their professional roles. Thirty-seven per cent are in internship, residency or fellowship. Nationally, a far smaller percentage (15%) of the nation's physicians are in house staff training.[1] This higher percentage of UMC graduates in house staff training reflects UMC's relatively brief history as a four-year school and its larger class size in recent years. An additional 8% of UMC graduates are fulfilling their military obligation. Tables 2 & 3 indicate the current activity of 855 Missouri graduates.

Ninety-seven per cent of those permanently established spend all or a portion of their professional time in patient care. Seventy-seven per cent are in the private practice of medicine. Nationally, 66% of physicians in 1972 were in private practice (office-based practice).[1] (This term, "office-based practice," is derived from AMA data and includes several small categories not included under our term of "private practice.") Of Missouri graduates in private practice, one third are in solo practice settings while the remainder are in group or partnership arrangements.

Twelve per cent of the permanently established graduates are either in institutional employment or

TABLE 2

CURRENT ACTIVITIES OF MU GRADUATES
N=855

	Number	*%*
Temporarily situated—in training programs, non-career military, etc.	383	45
Permanently situated—private practice, academic medicine, etc.	472	55

Percentages may not add to 100% due to rounding error.

associated with the federal government. These categories among others include career military roles and industrial employment. Of these 12%, one half spent more than 60% of their time in patient care.

An unexpected finding was that 45% of graduates permanently situated are associated with university medical centers. Ten per cent are in full-time academic medicine. The Faculty Roster Study of the AAMC, using a different sample, found 9.07% of Missouri-Columbia graduates in academic medicine in 1971 compared with a median percentage of 6.4% for 87 medical schools.[2] An additional 35% of UMC graduates have faculty appointments with a university medical center as a member of a clinical attending staff, as a preceptor or as a part-time faculty member. Although 80% of those in full-time academic medicine spend a portion of their time in research, the major activities for virtually all of these physicians are teaching and patient care.

WHAT SPECIALTIES HAVE UMC GRADUATES SELECTED?

Graduates of UMC have followed a pattern of residency selection parallel to physicians nationally.[1] Table 4 lists the percentage of graduates (both those permanently situated and those in training) who selected each major specialty area. National figures are virtually identical to those of the UMC graduates in all areas except dermatology, a field in which there has been greater local interest.

The percentage of graduates entering each specialty area has been consistent throughout the years with the exception of general practice, family medicine and internal medicine. Fig. 1 reflects the trends in these three specialties. A marked increase in the percentage of graduates entering internal medicine during the past few years is a reflection of both national patterns[3] and of major expansion of the Department of Medicine at the University of Missouri-Columbia.

TABLE 3

MAJOR ACTIVITY OF PERMANENTLY SITUATED GRADUATES
N=472

Major Activity Type		*% Involved*
Private practice		77
Solo	33	
Group/partner	58	
Other	9	
Academic medicine		10
Other institutional employment—industry, health centers, etc.		6
Government employment—career military, Public Health Service, etc.		6

Percentages may not add to 100% due to rounding error.

TABLE 4

SPECIALTY CHOICE

Specialty Area	*% Missouri Grads. N=854*		*% M.D.s Nationally[1] N=320,903*	
Family Medicine/ General Practice		17		17
Medical Specialties		23		17
Dermatology	4		1	
Internal Medicine	18		15	
Neurology	1		1	
Obstetrics/Gynecology		7		6
Pediatrics		7		6
Psychiatry		6		8
Surgery Specialties		20		20
General Surgery	8		10	
Orthopedics	5		3	
Otolaryngology	3		2	
Ophthalmology	2		3	
Urology	2		2	
Other Specialties		19		24
Anesthesia	4		4	
Pathology	4		4	
Radiology	4		5	
Other	7		11	
Unspecified		1		3

Percentages may not add to 100% due to rounding.

Although conceptual and behavioral differences between general practice and family medicine have been clearly defined, these differences were not recognized by the vast majority of our respondents. Consequently, we have combined data on general practice and family medicine. Twenty-eight per cent of graduates before 1961 entered the fields of general practice or family medicine. This had dropped to 17% in the classes between 1970 and 1973. With the development of family medicine as a new specialty, we now see major interest in family medicine by Missouri graduates. Eight per cent of the class of 1972 have entered family medicine training programs. Fifteen per cent of the class of 1973 have made similar plans, and 30% of the class which will graduate in June, 1974 currently plan to enter family medicine.

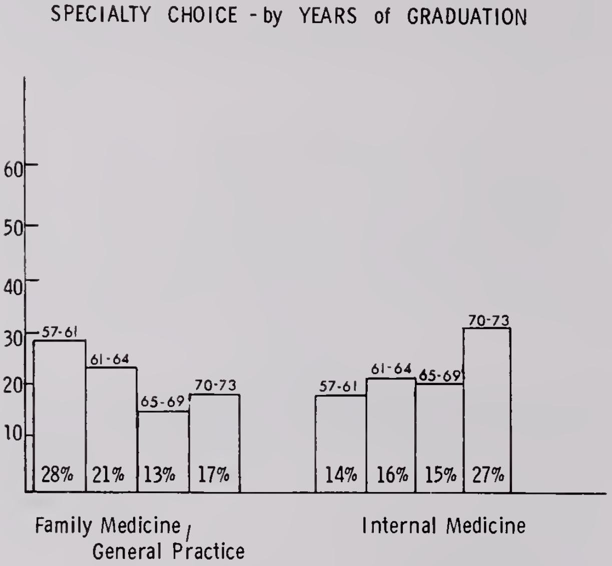

Fig. 1

TABLE 5

BOARD CERTIFICATION

Categories	% in Practice N=433	% in Training Planning* N=381
Board certified	58	82
Board eligible	27	15
Neither	15	3

* 41 respondents did not complete this question.

TABLE 6

RETENTION AND MIGRATION PATTERNS FOR MIDWESTERN STATE MEDICAL SCHOOL GRADUATES[5]

State University	% of Graduates Remaining in State to Practice	% of Graduates Going to California
Arkansas	43	5
Illinois	40	17
Iowa	36	14
Kansas	33	12
MISSOURI	44*	10
Nebraska	29	15
Oklahoma	36	8
Tennessee	40	4

The AMA DATA ABOVE is limited to alumni graduating up to the year 1967 and includes house staff.

* This figure (44%) differs slightly from our figure (46%) due to different sampling.

Increasing specialization is associated with longer periods of postgraduate training. Fewer and fewer physicians enter practice immediately after an internship. The permanently situated UMC graduates had an average of 3.7 years of postgraduate training and 17% had a single year. On the other hand, those currently in training programs plan an average of 4.3 years of postgraduate training and only 2% plan a single internship year. Weiskotten *et al* demonstrated that nationally, the 1935 medical school graduates averaged 2.6 years of postgraduate education while the 1950 graduates obtained an average of 3.4 years.[4]

Certification by a specialty board also is becoming a pattern for recent medical school graduates.[3] This certainly is reflected by our respondents (Table 5). Fifty-eight per cent of UMC graduates permanently situated are board certified and 85% are either board certified or board eligible. Of those in training, 82% expect to become board certified and 97% expect to be either board eligible or board certified. Nationally, 41% of the active-physician population is certified by a specialty board. The higher Missouri figures probably reflect national trends among recent medical school graduates to seek board certification.

Where Are They Located?

Forty-six per cent of the graduates have permanently settled in Missouri. Retention of Missouri graduates within Missouri compares favorably with our midwestern neighboring states (Table 6).[5]

The remaining graduates permanently settled are located in 40 other states with California attracting the largest percentage of 9% (Table 7). This mi-

TABLE 7

LOCATION OF GRADUATES (PERMANENTLY SITUATED)

State	%
MISSOURI	46
California	9
Texas	4
Florida	4
Washington	4
Colorado	3
Illinois	3
Kansas	2
Arizona	2
Michigan	2
31 other states	22
Total=41 states	

Percentages *may* not add to 100% due to rounding.

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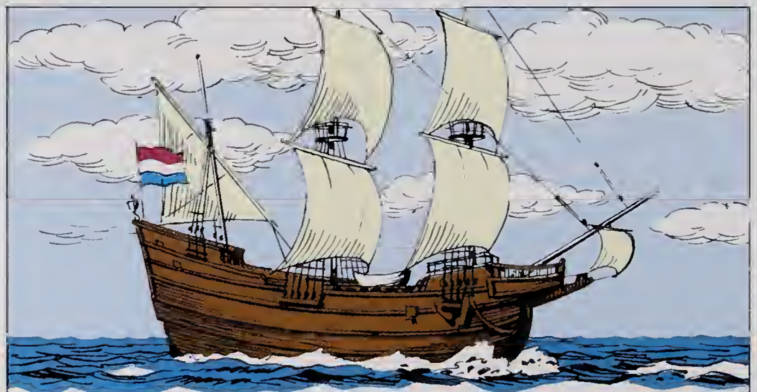

RONSSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

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MSMA NEWS ROUND-UP

MAY, 1974

MSMA dues increase approved

House says repeal of PSRO 'best'

The interests of the American people would best be served by the repeal of present Professional Standards Review organization legislation, according to a resolution passed by the House of Delegates of the Missouri State Medical Association.

Meeting at its 116th Annual Session, held at the Crown Center Hotel in Kansas City, the House debated and turned down a resolution which called for "non-compliance" with the PSRO law.

The resolution which was adopted stated that the MSMA and individual physicians should "work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care."

Also, the resolution expressed the hope that Congress "will respond by either repeal, modification or interpretation of rules which will protect the public."

A total of 41 resolutions submitted by Component Societies or individual members were considered by the House and 27 were either adopted or referred for further study. Also adopted were two Council resolutions, a Committee resolution and two Constitutional Amendments.

One of the Council resolutions which was passed will increase dues in the MSMA from $65 to $90 annually beginning January 1, 1975. The $10 assessment for continuation of the Student Loan Fund was also extended for three years. The dues increase was accompanied by proposals for expanding the services which the MSMA will be able to provide members. MSMA's current dues rank 48th among state societies and the $90 figure will still rank in the 25th percentile nationally.

The other Council resolution adopted was to honor Thomas P. Fox, who retired April 1 as Executive Assistant of the MSMA.

The Commission on Medical Economics, Third Party Medicine and Governmental Relations presented a resolution citing the fact that some physicians are dropping out of the Medicaid program and calling on the MSMA to approve the negotiation of a definite fee schedule and list of ancillary services provided for Title XIX recipients. The House adopted the resolution, which also provides that the fee schedule be renegotiated annually.

Of the Constitutional Amendments, one stipulates that the Speaker and Vice-Speaker of the House shall serve as Delegates-at-Large, thus negating the neccessity of the affected component societies to elect the two officers as Delegates from that society.

The other Amendment adopted affects the initiation of referendums under the MSMA Constitu-

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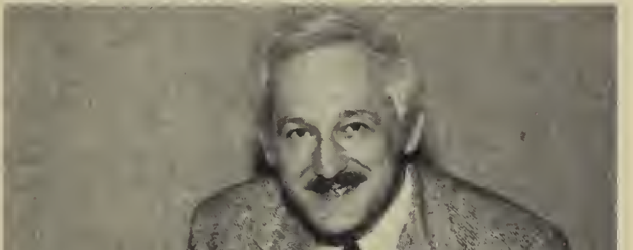

James C. Cope, M.D.
MSMA President

R. Allen Chandler, M.D.
MSMA President-Elect

House views government relations, legislation

tion. It reads: "Petition signed by 10% of the active members of the Association, including petitioners representing at least one-half of the component societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question."

The official minutes of the Annual Session will be published in the July Issue of MISSOURI MEDICINE. A summary of several Resolutions which were adopted included:

GOVERNMENTAL REGULATIONS

Discriminatory Fees — States that since the quality of care rendered by a physician is comparable regardless of his geographical location, the MSMA requests the State Insurance Commissioner to prohibit discrimination on the basis of geographical location, in the determination of reasonable fees for reimbursement by third party payers.

Use of Combination Drugs — Directs the physicians of Missouri, the MSMA and AMA to continue efforts to encourage the Food and Drug Administration to carefully study the prescribing habits of physicians before discontinuing a combination of drugs packaged together.

Pre-Admission Certification — Calls on Missouri physicians to continue to oppose hospital pre-admission certification vigorously.

Physician Involvement in CHP — Recognizes that Comprehensive Health Planning is no longer a "review and consent" organization but a true regulatory arm of the federal government. Urges all county societies to take official interest in local CHP's by appointing a physician representative to the organization and requests that this representative make regular reports to his local society and MSMA.

Wage-Price Regulations — Points out that Cost of Living Council Regulations are discriminatory for physicians. Directs the MSMA and AMA to take all feasible steps to gain discontinuance of the regulations.

PSRO in Government Hospitals — Describes PSRO as a cost containment measure for medical services rendered to persons under Social Security and calls on the federal government to (1) apply PSRO to government owned and controlled hospitals and extended care facilities in Missouri for a period of two years; (2) provide a report to the citizens of Missouri at the end of two years as to the benefits derived and problems encountered; and (3) requests that implementation of PSRO in non-governmental Missouri institutions be deferred pending the above report.

LEGISLATION

Seat Belt Legislation — Places the MSMA on record as favoring an automobile seat belt law being considered by the General Assembly of Missouri and directs the MSMA to inform Legislators of this position.

Drunk Drivers — Directs the MSMA to urge the Missouri General Assembly to remedy the problem of drunk drivers.

Teaching Human Physiology — States that since many diseases are the result of persons mistreating their bodies, the Missouri Department of Education should develop and implement factual, academically founded courses in the school system to teach human physiology and pathophysiology at the elementary and secondary levels.

Equal Rights Amendment — Calls upon the Missouri General Assembly to ratify the Equal Rights Amendment to the United States Constitution.

Complete Maternity Coverage — Resolves that all insurers offering maternity coverage policies must provide complete coverage "until termination of puerperium and until the newborn infant is discharged from the hospital."

Support of House Bill 1254 — Declares support of MSMA for Missouri House Bill 1254 which would establish pre-natal and high-risk infant care centers to prevent mental retardation.

National Health Insurance — Recognizes the move of the federal government toward establishing a national health insurance plan and resolves that any NHI must be designed with the consultation and aid of practicing physicians so that the welfare of patients will be the guiding principle of the plan.

Insurance for Mental Illness — Points out that many citizens are not adequately insured for mental or emotional illness and states support for a minimum insurance act requiring inpatient and outpatient mental health benefits in all health insurance policies issued in Missouri.

"Roy-Rogers Bill" — Expresses MSMA opposition to U.S. House Bill 12053 (Roy-Rogers Bill) which would consolidate many public health services and provide the mechanism to regulate physicians' fees, license facilities, certify the need for services and review quality of care.

HOSPITALS

Medical Staff Autonomy — Upholds the principle of hospital medical staff autonomy which states that the control of medical practice must remain in the sole hands of the medical staff, uncoerced and unrestricted by hospital administration. Also directs MSMA to make all physicians aware that certain forces in the hospital field are attempting to increase authority of hospital administration to control physicians on staffs. Urges physicians to be certain no bylaws changes are allowed in hospitals which would dilute a physician's authority to use his best medical judgment in patient care.

Hospital Board-Staff — Explains that the "Darling Decision" has been erroneously interpreted on the part of some hospital boards to attempt to exercise direction and supervision over staff physicians. Directs MSMA to provide members with true implications of "Darling Decision."

INTERNAL AFFAIRS

Unified AMA-MSMA Membership — Asks consideration of the Constitution and Bylaws to the effect that all MSMA members shall also be AMA members. Instructs Council to assure that full and ample discussion of this issue occur in each Councilor District and in each Component Society "to the end that this resolution in a formal manner be

Continued on Back Page

Council officers

Max S. Franklin, M.D., of St. Louis (center), was elected Chairman of the MSMA Council following the 116th Annual Session. Howard J. McAlhany, M.D., of Springfield (right), was selected Vice Chairman. A new Councilor, Andrew McCanse, M.D., of Kansas City, was elected to represent the Seventh District.

Dr. Chandler is President-Elect

Dr. James C. Cope assumes MSMA Presidency

James C. Cope, M.D., of Columbia, was installed as President of the Missouri State Medical Association during ceremonies at the 116th Annual Session, April 4-7, in Kansas City.

Dr. Cope has served as President-Elect the past year. He succeeds E. A. Stricker, M.D., of St. James.

R. Allen Chandler, M.D., of Kansas City, was unanimously selected President-Elect of the MSMA and will assume the Presidency at the 1975 Annual Session.

Dr. Chandler is Immediate Past Chairman of the MSMA Council and has served as Councilor from the Seventh District.

Delegates to the House elected a new AMA Delegate and Alternate and three new Vice Presidents of the Association.

Rae W. Froelich, M.D., of Lebanon, currently an Alternate Delegate was elected AMA Delegate to succeed Loren Washburn, M.D., of Versailles, who did not seek re-election. Selected to replace Dr. Froelich as Alternate was Melvin C. Kasten, M.D., of Cape Girardeau. Drs. Froelich and Kasten will assume their new posts January 1, 1975.

Stanley S. Peterson, M.D., of Springfield, was re-elected as an AMA Delegate and James C. Sisk, M.D., Clayton, was re-elected Alternate Delegate.

Serving as Vice Presidents of the MSMA for 1974-75 are Drs. James E. Campbell, Macon; Frederick J. McCoy, Kansas City; and Robert A. Mayer, St. Louis.

The House re-elected Speaker Robert A. Slickman, M.D., Kansas City, and Vice Speaker James T. Brown, M.D., Springfield.

Max S. Franklin, M.D., of St. Louis, was elected Chairman of the Council of the MSMA at the Council's organizational meeting following the 116th Annual Session.

Dr. Franklin served as Vice Chairman the past year.

Howard J. McAlhany, M.D., of Springfield, was elected Vice Chairman for 1974-75 term.

In Councilor District elections conducted during the Annual Session, Andrew McCanse, M.D., of Kansas City, was selected to succeed R. Allen Chandler, M.D., as Councilor from the Seventh District.

Four Councilors were re-elected to their posts during Councilor District meetings. Those re-elected were: First District, John N. Martin, M.D., of St. Joseph; Third District, Max S. Franklin, M.D., of St. Louis; Fifth District, Robert E. Bregant, M.D., of Jefferson City; Ninth District, Claude W. Cooper, M.D., of Thayer.

The Council re-elected John I. Matthews, M.D., of Jefferson City, as Secretary, and Donald R. Judd, M.D., of St. Louis, as Treasurer.

Voluntary restraint on fee increases urged by Stricker

With wage-price controls over physician's fees seemingly about to expire, Dr. E. A. Stricker, St. James, Immediate Past President of the MSMA, called on MSMA members to use restraint in increasing medical costs.

In his statement before the House of Delegates at the 116th Annual Session, Dr. Stricker said:

"I'm sure most of you are aware of the recent actions taken by the appropriate committees of the United States Congress in refusing to extend wage-price controls in limited areas of the economy.

"I feel certain that the membership of MSMA agrees with this action and I believe that it is the general sense of most economists, government officials, and the general public that unrealistic controls cause severe economic and social distortions, which ultimately do not work to the public good.

"Let us as physicians, in the future, as well as in the past, always be aware of the public need and the public good. I congratulate you, the membership, for your cooperation and efforts to date. While you cannot live apart from the economic effects of the times, I encourage your vigorous efforts and support in combating the common enemy — inflation.

"Let us in the health care field voluntarily exert our best efforts to restrain rising costs to the greatest extent possible and consistent with the delivery of the finest medical care that it is possible to bring to our patients and the public."

Dr. Huntington named

Ione Huntington, M.D., has been named acting superintendent of the Missouri State Chest Hospital in Mt. Vernon.

Dr. Huntington has been a staff physician at the hospital since September of 1969 and was serving as acting chief of medicine prior to her appointment as acting superintendent.

She replaces Dr. Charles A. Brasher, who died March 3 of an apparent heart attack. Dr. Brasher had been superintendent and medical director of the hospital for more than 30 years.

Continued from Previous Page

brought before the House of Delegates at the First Session of the 1975 Annual Meeting of the Association."

Constitutional Convention — Refers to the Planning Committee a resolution calling for a Constitutional Convention to reapportion the MSMA along the one-man, one-vote guidelines.

Improved Communications — Resolves that a portion of the dues increase be used to employ additional field men to work with the physicians of Missouri in carrying out the business of the MSMA.

MISCELLANEOUS

Malpractice Insurance — Requests that the Council attempt to develop a malpractice program for members in an effort to meet the problems of rising insurance premiums and refusal of companies to issue policies to some physicians.

Third Party Involvement — Points out the increasing tendency of third party payers to make capricious rulings as to procedures and fees and directs that all persons or organizations be informed that decisions involving physician care must be discussed with the involved physicians (or their representatives) before changes are made.

Politics in V.A. Hospitals — States that since the PSRO Law relieves the legislative branch of government from any utilization review in public and private hospitals by placing the responsibility with the Department of HEW, all requests by patients and veterans' representatives be sent directly to H.E.W. without benefit of a personal form letter from a legislator.

AMA-ERF Recipient — Recommends that student recipients of loans from the AMA-ERF be assigned to a physician actively caring for patients. This physician is to act as confidant, friend, advisor and representative of organized medicine.

Dr. A.N. Vaughn Citation — Directs that Dr. Authur N. Vaughn, St. Louis, be the recipient of a posthumous citation from the MSMA for his outstanding, noteworthy and exemplary contribution to medical education and post graduate training, particularly in the area of development of black surgical leadership.

Hill-Burton funds available for state

The State Division of Health has learned that Missouri will receive an estimated $8.9 million in federal Hill-Burton categorical grant fundings as the state's share of Congressional appropriations for the 1973 and 1974 fiscal years. The money will be available to assist qualifying projects for the construction of health facilities in Missouri.

In addition to these grant funds, DHEW has announced that Missouri has been allocated $13.8 million in loan principal under provisions of the Hill-Burton loan guarantee program which involves a 3 percent interest subsidy. Both the categorical grant and the guaranteed loan programs are administered in Missouri by the Bureau of Health Facility Planning and Construction of the Division of Health.

All applications as well as inquiries for additional information should be sent to the Bureau of Health Facility Planning and Construction, Missouri Division of Health, P. O. Box 570, Jefferson City, Mo. 65101.

TABLE 8

DISTRIBUTION OF UMC GRADUATES WITHIN MISSOURI (PERMANENTLY SITUATED)
N=212

	% of Mo.-Columbia Graduates	*% of State's Physicians*[6]	*% of State's Population*[7]
Major metropolitan counties*	31	64	50
Middle urban counties†	38	15	11
Remainder of state	31	21	39

* St. Louis City, St. Louis, St. Charles, and Jackson Counties.
† Greene County, Boone County, Jasper County, Cole County, Cape Girardeau County.

gration to California is a reflection of both regional and national patterns. The neighboring states of Kansas, Iowa, Nebraska and Illinois have placed between 12% and 17% of their graduates in California (Table 6). Using data from the 1967 study by the American Medical Association on medical school alumni, we found that 60% of the nation's medical schools have more graduates located in California than in any other state but their own.[5]

Of those who have settled in Missouri, 19% are in Columbia, 18% in Kansas City, 12% in St. Louis and 9% in Springfield. The remaining 42% are located in 44 other smaller communities across the state.

The previous paragraph suggests that Missouri graduates have tended to serve areas outside the major metropolitan cities of St. Louis and Kansas City (Table 8). Thus, 69% of UMC graduates settling within the state are located in nonmetropolitan areas containing 36% of the state's physicians and 50% of the state's population. Thirty-eight per cent of UMC graduates in Missouri have settled in middle-sized communities such as Columbia, Jefferson City, Springfield, Cape Girardeau and Joplin —cities which have assumed major roles as regional medical centers and serve large rural areas.

Nonmetropolitan practice also is a pattern for UMC graduates located in other states. Table 9 indicates that 27% have chosen counties with population centers of less than 50,000 as compared with 13% of physicians nationally.

TABLE 9

NATIONAL DISTRIBUTION OF UMC GRADUATES BY PRACTICE SITE AND COUNTY SIZE (PERMANENTLY SITUATED)

Size of Practice County	*% of Mo. Graduates N=460*	*% of Physicians Nationally*[8]	*% of U.S. Population*[8]
Nonmetropolitan counties with population center(s) less than or equal to 50,000 people	27	13	26
Metropolitan counties with population center(s) greater than 50,000 and county population of 50,000-500,000	30	19	21
Metropolitan counties with population center(s) greater than 50,000 and county population greater than 500,000	43	68	53

Percentages may not add to 100% due to rounding error.

WHAT FACTORS PREDICTED PRACTICE LOCATION?

A physician's ultimate decision upon where to practice has many determinants. Among these can be included state of origin, location of medical school, internship and residency training, personal preferences, family roots, attitudes of spouse and environmental or economic considerations.[4, 9-13] Our study focused on two factors: (1) The relationship of location of residency training to practice location and (2) the relationship of hometown size to practice-community size.

As already indicated, the UMC graduate had a 46% chance of ultimately practicing within the state. If the graduate also took his residency in the state, he had a 72% chance of remaining in the state. However, the graduate who took his residency elsewhere had only a 30% chance of returning to the state.

The percentage of alumni returning to Missouri varied markedly with the section of the country in

This article represents the first study of the graduates from the four-year curriculum at the University of Missouri-Columbia School of Medicine (UMC). In addition to reviewing the current activities of UMC graduates, the authors offer suggestions for increasing the medical manpower in Missouri. Mr. Cullison is a third-year student at the University of Missouri School of Medicine. Dr. Reid is Associate Professor of Education and a member of the Educational Resources Group of the School of Medicine. Dr. Colwill is Associate Dean and Director of the Family Medical Care Program at the Medical Center.

which they obtained their house staff training. Only 7% of those who completed house staff training on the West Coast returned to Missouri. On the other hand, 42% of graduates who took house staff training in contiguous states returned to Missouri.

A striking relationship was found between home town community size and the community size in which the physician decided to practice. If the graduate came from a community of less than 50,000, he had approximately three chances in four of settling in a community of less than 500,000. He had only one chance in four of settling in a community of greater than 500,000. If, on the other hand, he came from a community of greater than 500,000, he had almost a 50% chance of returning to a community of greater than 500,000. Much of the tendency for the rural graduate to seek a rural practice is associated with a greater tendency of these graduates to enter general or family practice. While UMC graduates have tended to seek a non-metropolitan practice location, only 7% have sought to practice in communities of less than 5,000. Of this group who have settled in communities of less than 5,000, one half came from communities of that size. These data are presented in greater detail in another publication.[14]

Where Do Recent Graduates Plan to Practice?

Forty-five per cent of Missouri graduates indicated that they were either in training or were fulfilling their military obligation. With few exceptions, they mirror the pattern set by the 55% who are already in practice. One third of those in training expect to complete that training in Missouri. The next largest group (9.4%) expects to complete their training in California. The remaining graduates list 35 other states in which they plan to complete their residencies. This pattern of house staff training approximates that found with the earlier graduates who are now in practice.

More than half of those in training remain undecided about their ultimate practice location. Among those who are decided, half plan to return to Missouri and 10% plan to settle in California—a pattern virtually identical to the Missouri graduates who have already entered practice.

Of the 90 who have decided to return to Missouri, half plan to settle either in St. Louis or Kansas City. Twenty-nine per cent plan to settle in Springfield, Columbia, Jefferson City, Joplin or Cape Girardeau. The remaining 20% will practice in other communities across the state. This increased percentage planning to settle in St. Louis and Kansas City may be related to the greater percentage of recent graduates from these cities. Thirty per cent of those permanently situated came from these metropolitan areas while approximately 50% of those in training came from the same metropolitan areas of Missouri.

Earlier, we noted a relationship among those already settled between practice location and the state where house staff training was obtained. This relationship again holds true for those in training who have decided upon their site of practice. Thus, 83% of those taking house staff training in Missouri plan to stay in Missouri. At the other extreme, only 13% of those taking house staff training on the West Coast plan to return to Missouri. One third of those training in 33 other states plan to return.

Comments

In this paper, we have presented a variety of associations based upon past events. These associations may or may not determine the direction of future trends. This section of the paper emphasizes some of the most significant observations and associations. In addition, the authors feel that opportunities are suggested by the data to increase the number of physicians for Missouri.

In some respects, Missouri graduates have followed patterns analogous to graduates of other medical schools. They overwhelmingly entered the private practice of medicine and selected specialties consistent with national patterns. Their practice location has shown association with the geographic location of their home, medical school and residency training program. This trend has been previously documented nationally by other studies of medical school graduates.[4, 9, 10] The Missouri graduate who entered the rural practice of medicine generally had a rural background. This relationship also has been noted by others on the national level.[12, 13] Missouri graduates who have a metropolitan practice generally had a metropolitan background. We suspect this also is a national pattern.

In other respects, UMC graduates are unlike medical school graduates nationally. Missouri graduates have tended to settle outside the major metropolitan areas in small or middle-sized communities. In so doing, many are practicing in medically underserved areas. We have noted three factors associated with this trend. First, a large proportion of those graduates who are permanently settled have relatively small town roots. Fifty-eight per cent of those in practice grew up in communities of 50,000 or less. Secondly, the rural graduate was more likely to choose general or family practice and physicians in these specialties more frequently entered nonmetropolitan practice. Thirdly, they attended medical school in a relatively small community.[15] Less than 10% of the nation's medical schools are in communities such as Columbia with populations of less than 100,000.

Additional physician manpower is a prime concern for the state of Missouri. Sixty-three per cent of Missouri graduates seek house staff training outside the state. In the past, only 30% of this group have returned to Missouri to practice. This tendency of Missouri graduates to leave the state seems to have two determinants. Most Missouri students have grown up in Missouri. Many have attended colleges in Missouri, and all have completed medical school in Missouri. This long-term residence in Missouri is cited by many senior students as a major reason for leaving the state for house staff training. Secondly, Missouri graduates are increasingly seeking university-based house staff programs. In 1967, 22% of the graduates interned in a university medical center. In 1972, 82% interned in university medical centers. They leave the state to seek programs which they perceive to be of highest caliber.

The fact that a large percentage of graduates leave the state for house staff training does not necessarily indicate that they plan to settle outside Missouri. Indeed, more than half of the Missouri graduates still in training have yet to decide where to settle. Data generated by Yett and Sloan also suggest that medical school graduates do not select their residencies based upon an intention to practice in that location.[9]

Based upon the above observations, a dual approach to increasing the number of physicians in Missouri might be suggested: (1) every effort should be made to enhance the variety, quality and attractiveness of residency programs in Missouri and (2) coordinated efforts should be developed to maintain contact with graduates of Missouri medical schools who are in residency training elsewhere. These physicians have close ties and interest in Missouri and are a logical group for recruitment efforts.

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Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

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in Brief

A summary of AMA, medical & health news

American Medical Association/535 North Dearborn Street/Chicago, Illinois 60610/Phone (312) 527-1500/TWX 910-221-0300

Elected chairman of the AMA's Board of Trustees at its March meeting, was Richard E. Palmer, M.D. John M. Chenault, M.D., was named vice-chairman. The elections followed the appointment of James H. Sammons, M.D. as the AMA's executive vice-president designate. Dr. Sammons had been Board chairman since October, 1973, and will succeed Ernest B. Howard, M.D., when he retires, March 1, 1975.

Six areas of priority activity were approved by the Medical Liability Commission, a group representing 19 national organizations of medical care providers. Patient safety; provider qualifications; alternative procedures, including arbitration, mediation, screening panels, etc.; data collection; legal doctrine; and liability insurance are the priorities. The AMA, one of the founding organizations of the commission, has provided staff services and facilities for the group since its incorporation in August, 1973.

In a statement in the February 28 *Federal Register*, the Bureau of Motor Carrier Safety closed the docket on a proposal by the Idaho Association of Chiropractic Physicians to allow chiropractors to perform periodic medical examinations on drivers of commercial vehicles. The bureau said that "it would be unwise to accept, as fulfilling the requirement of a periodic medical examination, an examination of a driver performed by a chiropractic physician."

The decline in the infant mortality rate in the U. S. continued in 1973. The National Center for Health Statistics reported last year's infant mortality rate to be 17.6 per 1,000 live births, the lowest in history. The rate was 18.2 in 1972, 19.2 in 1971 and 19.8 in 1970.

Health problems in business and industry prompted the AMA to develop an employee health education program, "Good Health is Good Business," for corporations and institutions. Initially, the AMA will provide programs for 250 companies, identifying the health education needs of individual firms, providing brochures for employee distribution and offering counseling and services. Interested companies should contact Dept. of Field Services, AMA Headquarters.

$94.1 billion was spent on health care in the U. S. in fiscal 1973, up 11% from fiscal 1972. It was the lowest rate advance in several years. The Gross National Product rose 10.9% in fiscal 1973, and health spending remained 7.7% of the GNP, with each person spending an average of $441 on health. Direct payments averaged $132, private health insurance paid 26% of personal health bills and government paid 38%. Spending rose 10.7% for hospital care and 8.5% for physicians' services.

The U. S. Commissioner of Education has recognized AMA's Council on Medical Education to work with 28 national professional organizations in accrediting educational programs for 17 allied medical occupations. The action renews the recognition of accreditation activities for seven programs and extends the scope of recognition to include ten additional occupations.

The 114 U. S. Medical schools received $1,265,000 in grants from the AMA-ERF this year. It is the largest amount in ten years and the fifth largest since the program began 23 years ago. Another AMA-ERF program, the Loan Guarantee Program for medical students, interns and residents, has guaranteed 51,797 loans worth $59,481,298 since 1962. In calendar year 1973, AMA-ERF received $1,921,112.94 in contributions from sources including the Woman's Auxiliary to the AMA, physicians, foundations, state, county and other medical societies and the pharmaceutical industry.

Four workshops on regional emergency medical response systems will be sponsored by AMA-ERF through a $59,700 grant from the Robert Wood Johnson Foundation. The grant will fund workshops to help community groups and institutions seeking to improve emergency care in their regions.

Missouri Physicians Receive AMA Recognition Award for Continuing Medical Education

A total of 136 Missouri physicians recently received the 1972 AMA Physician's Recognition Award.

The award is to recognize, encourage and support physicians who participate in continuing medical education and to emphasize the need for developing more meaningful continuing education opportunities.

The Physician's Recognition Award is granted to those physicians who complete a minimum of 150 credit hours of continuing medical education over a three-year period.

The following physicians received the 1972 award:

Drs. Michael R. Redmond, *Ballwin;* Daikichi Hata, *Boonville;* Jon P. Downey and David N. Jones, *Cape Girardeau;* Emil F. Miskovsky and Herman Shyken, *Clayton;* Francis G. Pipkin, *Clinton;* William C. Allen, Jerry E. Foote, Emily W. Guyer, Kenneth M. Kays, William D. Lerner and John T. Logue, *Columbia;* Robert H. Sueper and George E. Wettach, *Creve Coeur;* Andres S. Bonifacio and James L. Mayfield, *Crystal City.*

Drs. Charles H. Appleberry, *Flat River;* Galileu Cabral, *Florissant;* A. Ramamohanarao and Chaiyarat Sermchief, *Fredericktown;* James M. Goforth and John L. Jenkins, *Ft. Leonard Wood;* Donald M. Wald, *Gladstone;* Roger T. Crenshaw and Theresa E. B. Crenshaw, *Glendale;* William H. Hickerson, *Independence;* G. Donald Shull, *Jefferson City* and Frederick M. Brandon and Marvin A. Singleton, *Joplin.*

Drs. Chaudhary M. Asghar, John W. Collins, Jerry W. Cook, Lowell L. Davis, Jose B. Faraon, Morris L. Friedman, William J. Huse, Walter H. Jacobs, Marvin Kahn, Andrew B. Kaufman, B. Albert Lieberman, Roberto Lopez-Plata, Sidney F. Pakula, Kenneth A. Powell, Harry Statland, George X. Trimble, Leonardo C. Viril and George P. Williams, all of *Kansas City.*

Drs. John R. Nelson, *Kirkwood;* Glenn E. Miles and Lawrence G. Stuerman, *Louisiana;* Robert G. McConnell and Michael R. Richmond, *Manchester;* Theodore George, *Marceline;* Jacob W. Fleming, *Moberly;* Theerawat Pattaropong, *New Madrid;* Newton C. McCluggage, *North Kansas City;* Mario L. Carrera, *Overland;* Quentin Cramer, *Parkville;* Emilio M. Canlas, Ricardo M. Ramirez and Bennie N. Till, *Poplar Bluff;* Vicente W. Kwan, *Potosi.*

Drs. Leon J. Galinsky, *Republic;* Eugene F. White, *Rolla;* John C. Soucy, *St. Charles;* William A. Challener and David G. Windsor, *St. Joseph.*

The following physicians are from the City of St. Louis:

Drs. Robert E. Bolinske, Putchara Boonprakong, Vallop Boonprakong, Benje Boonshaft, Arnold G. Brody, John P. Carmody, Suresh Chand, Sei Y. Choi, Jorge A. Covarrubias, Maurice A. Diehr.

Drs. Robert C. Drews, Joseph C. Edwards, James A. Felts, Leonard P. T. Fitzgerald, James S. Floerchinger, Max S. Franklin, James M. Gordon, William D. Hawker, Barbara L. Herjanic, Yasuo Ishida, John L. Keltner, Stanley W. Kim, Melvin B. Kirstein.

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Drs. Hugo L. Ramirez, Syed A. Raza, Marvin Rennard, David Rothman, Nicholas L. Schenck, David J. Schreiber, Luis H. Schwarz, Robert H. Shipp, Barry A. Siegel, Fawzi M. Soliman, Chotchai Spisuro, Alan Sugar, Clement J. Sullivan.

Drs. Robert W. Tichenor, Jaime Vargas, Mohamed S. Ahmad Wahba, Stephen R. Waltman, Alan N. Weiss, Bruce I. White, James R. Wiant, Fred W. Witt, and Eliza E. Wochnik.

Drs. Carl G. Popp and Roy T. Waltrip, *Sikeston;* Daniel L. Dolan, Philip R. Fogle, Philip J. LeFevre and Norman J. Schreiber, *Springfield;* Robert M. Crawford. *Sullivan;* Charles R. Blackwell, *University City;* Keith D. Jones, *Warrensburg;* and Ronald K. Grady, *Webster Groves.*

MSMA Woman's Auxiliary Elects Mrs. George J. Lytton

Mrs. George J. Lytton, Kansas City, was elected President of the MSMA Woman's Auxiliary at the annual meeting at Crown Center Hotel in Kansas City on April 5-6.

Mrs. Lytton is a Past-President of Jackson County Medical Auxiliary. Active in community affairs, she has served as a board member of the Woman's City Club, Research Hospital Auxiliary, Woman's Council of UMKC, Urban League, St. Luke's Staff Wives and as president of Alpha Xi Delta Mothers' Club.

She is a graduate of Peru (Neb.) State College with a major in Music and English and has taught in four high schools.

An accomplished pianist and organist, she is a member of the Women's Committee for the Conservatory of Music, Woman's Division of the Kansas City Philharmonic and the Lyric Opera Guide.

Dr. and Mrs. Lytton are the parents of three children—Jim, Barbara and John.

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Usage in Pregnancy: See "Contraindications."

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ERWIN R. RABIN, M.D., ***St. Louis***

Measles and the Central Nervous System

A Review

IN THE PAST FIVE to ten years, a number of investigators have made exciting observations linking measles virus to a rare form of chronic brain damage, subacute sclerosing panencephalitis (SSPE). This disease runs a progressively fatal course affecting children and young adults. The recent attention this illness has received is considerably out of proportion to its incidence. However, an understanding and control of SSPE may set the stage for similar progress with other chronic neurologic illnesses, most notably multiple sclerosis.

HISTORICAL BACKGROUND

In 1933, Dawson[1] proposed a viral etiology for a fatal neurologic illness in which both intranuclear and intracytoplasmic inclusion bodies were present in cells of the brain. He did not consider that the virus was herpes simplex because intracerebral inoculation of the affected brain into rabbits did not induce necrotizing encephalitis. Little more of note occurred in the history of SSPE until more than 20 years later when in 1965, Bouteille *et al*[2] and in 1966, Tellez-Nagel and Harter[3] reported patients with subacute encephalitis. These workers, using electron microscopy, observed that the intranuclear inclusions were composed of filamentous tubules resembling the ultrastructure of inclusions from cells infected with measles virus.

In 1967, Connolly *et al*[4] provided the next important link between measles virus and SSPE by showing that measles virus antibody was present in serum and cerebrospinal fluid in three affected patients. Moreover, they demonstrated by immunofluorescence that measles antigen was present in the brain. Then in 1969, Horta-Barbosa *et al*[5] reported recovery of complete infectious measles virus from the brain of a patient with SSPE by cocultivation of brain fibroblasts with Hela cells. In the same year, Payne and coworkers[6] reported that they, too, had isolated measles virus from a patient with SSPE by cocultivation of the patient's brain cells with green-monkey cells. In 1971, Horta-Barbosa *et al*[7] reported that measles virus is found not only in the brain of patients with SSPE, but can be recovered from lymph nodes by cocultivation with Hela cells.

PATHOGENESIS

Although the relationship of measles to SSPE is well documented, the pathogenesis of SSPE is still uncertain. Acute measles infection precedes SSPE by periods varying from several months to many years. The SSPE registry released data indicating a relationship to measles infection occurring before two years of age in 50 of 95 patients (55%).[8] The mean age of onset of the disease is 7.2 years. Presumably, virus invades the brain during the acute infection and remains dormant in as yet an undefined state. The factors responsible for the initiation and inexorable progression of the disease are poorly understood. The first step in defining the pathogenesis of SSPE is an understanding of what

Current evidence suggests that measles virus directly invades the brain and causes various forms of neurologic disorders in man including acute and subacute encephalitis and subacute sclerosing panencephalitis (SSPE), which is a rare, chronic, fatal illness. The author believes that the recent attention this illness has received is out of proportion to its incidence. He adds, however, that "an understanding and control of SSPE may set the stage for similar progress with other chronic neurologic illnesses, most notably multiple sclerosis." Dr. Rabin is from the Department of Pathology and Laboratory Medicine, The Jewish Hospital of St. Louis and is Associate Professor, Department of Pathology, Washington University School of Medicine.

happens to the brain during acute measles infection.

Both electroencephalographic (EEG) and cerebrospinal fluid (CSF) changes occur during uncomplicated measles. Gibbs *et al*[9] reported abnormally slow EEGs in 344 (51%) of 680 patients with measles without clinically evident encephalitis. Pampiglione[10] reports that all 22 children studied during a 1963 epidemic had an abnormal EEG when tested one to four days before the rash appeared. Ojala[11] studied changes in CSF during measles in 127 patients of which only four had clinical evidence of brain involvement. Pleocytosis in the CSF of greater than ten cells per cubic milimeter was present in 15 (12%) of the 127 patients. Dayan and Stokes[12] report immunofluorescent detection of measles virus antigen in CSF cells in patients with SSPE. This same technique could be applied to determine CNS viral invasion in uncomplicated measles or suspected measles encephalitis.

Adams *et al*[13] from a study of 20 fatal cases of measles encephalitis, proposed that measles virus directly invades the brain and causes encephalitis. They found characteristic inclusion bodies in the brain in 15 cases and multinucleated giant cells in five cases. Both inclusion bodies and syncytial giant cells are hallmarks of direct involvement by measles virus. In almost all of the 20 fatal cases, these investigators observed perivascular infiltration with accompanying demyelinization. In the more chronic cases, they observed fusion of perivenous areas with large sclerotic plaques.

It is highly probable, in view of the EEG abnormalities and CSF pleocytosis, that viral involvement of the CNS occurs during the viremic phase of acute measles in a substantial number of patients. The cellular reaction in the brain may well be identical to the response initiated by direct viral involvement in the skin and oral mucosa (Koplik's spots).[14] In the brain, however, the cellular reaction generally proceeds at a subclinical level. In the large majority of patients, virus is destroyed in the brain as it is in other sites, and recovery ensues. In a few patients, virus proliferates and clinical encephalitis, which is associated with a significant mortality, develops. The incidence of measles encephalitis which varies with the epidemic and age of those affected is generally one per 1,000 infected patients.[15] In a very small number of patients, virus invades the brain during acute measles and is harbored there in a subclinical state for an indefinite period prior to the development of SSPE. The incidence of SSPE is one per million of the population of the United States.[8] Whether or not patients with SSPE have EEG abnormalities or CSF pleocytosis during the subclinical period prior to manifest disease is unknown.

How does measles encephalitis differ from SSPE? The longer interval between disease and measles infection and slower progression of the illness separate SSPE from measles encephalitis. However, these two diseases have some remarkable similarities. On occasion, it may be difficult to classify an illness as one or the other. Demyelinization, inclusion bodies and, almost certainly, virus are present in the brain in both diseases. Generalized infection occurs in both; many of the fatal cases of measles encephalitis have associated giant cell pneumonia[13] and lymph nodes from patients with SSPE contain virus.[7] It is probable that the differences between measles encephalitis and SSPE are due to host immunologic factors in conjunction with different strains of virus.

Experimentally, measles can proliferate in the brain of mice and cause fatal encephalitis. Wear *et al*[16] describe tubular structures in the brain cells of mice infected with measles virus. They conclude that the acute fatal encephalitis is a direct involvement of brain cells by measles virus. Wear and Rapp[17] report the induction of latent measles infection by intracranial inoculation of suckling hamsters who are the progeny of mothers previously immunized with measles virus. Moreover, when these animals received the immunosuppresent, cyclophosphamide, an illness resembling SSPE became manifest. A chronic neurologic disease resembling SSPE has been reported by Byington and Johnson[18] in hamsters intracranially inoculated with an SSPE (measles) agent. Age was a critical factor in the experiments. Weanling hamsters developed the chronic neurologic infection, adults developed a nonfatal self-limited encephalitis and newborns had a uniformly fatal encephalitis.

Koprowski *et al*[19] propose the hypothesis that SSPE may be the result of two viruses, a paramyxovirus plus a helper, Papova-like virus. They observe by electron microscopy in one SSPE human brain culture not only paramyxovirus-like or measles-like particles but, also, particles resembling Papova virus. They postulate that Papova-like virus, present in a symbiotic state in human tissue, may be "activated" by syncytiogenic paramyxovirus to induce SSPE. Brody and Detels,[20] from epidemiologic data, also propose that SSPE is the result of a simultaneous infection with two agents, measles virus plus an animal virus. They consider that the animal virus is probably a Papova-like zoonotic agent which acts to precipitate SSPE in a patient with subclinical persistent measles infection. However, the role of another virus in addition to measles in SSPE remains to be proved.

Immunologic Aspects

Burnet[21] drew attention to measles as an index of immunological function. He considers the eruptive stage of measles and the development of permanent immunity to be mediated by thymic dependent immunocytes. In children with congenital agammaglobulinemia, measles, like many other viral infections, is no different in its clinical progression from measles in normal children.[22] Little or no globulin is present in the circulation of these patients but immunity to the virus still develops. In contrast, when cellular immunity is impaired, as in cortisone-treated acute leukemia, measles infection may result in a fatal giant cell pneumonia without rash. Burnet[21] believes that the absence of delayed hypersensitivity permits cells infected by measles to infect other cells rather than be destroyed in the inflammatory process. Such may be the basis for progressive disease manifest by giant cell pneumonia and encephalitis.

Burnet[21] reasons that failure of thymic dependent immunocytes in SSPE is acquired. He postulates that, at the end of an acute measles infection, a few infected cells remain in the brain and thymus. A slow, cell-to-cell progression of measles infection in the thymus provides a constant course of measles antigen and prevents recruitment of thymic dependent immunocytes. Consequently, only thymic dependent immunocytes which present during the primary measles infection are available for host defense against virus in the brain. When these cells are reduced and destroyed, SSPE ensues. The implications of this hypothesis are that SSPE patients will fail to react to skin-test measles antigens and that their thymus will contain measles antigen. Measles virus has been recovered from lymph nodes of patients with SSPE, but recovery of measles from thymus of patients with SSPE has not as yet been reported. Giant cells[23] and measles antigen[24] have been reported in the thymus of patients with disseminated infection. Postmortem examination with cocultivation of thymus from patients with SSPE could prove whether or not virus is present.

Recent reports regarding immunologic status of patients with SSPE are conflicting. Some investigators note that lymphocytes from these patients are defective in response to measles antigen,[25–27] whereas others[28, 29] have made contrary observations. Lischner *et al*[30] attempt to explain this discrepancy in part on the basis of test antigen impurity, variability or instability. They propose that this problem may be circumvented by use of measles-induced, cell-surface antigens rather than viral antigens, and suggest that the method of Labowskie *et al*[31] may prove useful in this regard. Mizutani[32] accounts for the conflicting data suggesting instability of cell-mediated immunity to measles virus in patients with SSPE. Ahmed *et al*[33] notes that two patients with SSPE exhibited a factor in their serum and CSF which blocks *in vitro* responses of cell-mediated immunity to measles antigen. It seems likely from the evidence to date that impaired cell-mediated immunity occurs in SSPE and that the defect is specific for measles antigen rather than a generalized cell-mediated impairment. The problem requiring clarification is how this defect develops and its significance in the course of the disease.

Zweiman[34] indicates a direct *in vitro* effect of measles virus on human lymphocytes. Measles virus inhibits the proliferative response of lymphocytes stimulated with phytohemagglutinin-P in culture. When autologous serum is used, only lymphocytes from measles-susceptible individuals are inhibited. The direct effect of measles on lymphocytes may explain the depression of delayed skin test reactivity following both natural or vaccination-type measles infection. This property of directly inhibiting a lymphocytic population deserves more study in regard to its effect on promoting "slow" or persistent virus infection.

Ter Meulen *et al*[35] observed measles antigen-antibody complexes in nerve and glial cells in brain tissue from a case of SSPE. They report measles antigen in dendrites and suggest that viral infection could proceed from cell to cell in face of large amounts of antibody present in the environment. All cells in which antigen-antibody complexes are demonstrated are dead or dying, and irreversible damage to these brain cells may be the result of cytotoxic action of antibody and complement. Dayan and Stokes[36] describe immune complexes in the kidney of one patient with SSPE which was studied at autopsy. Granular deposits of complement, IgG and measles antigen are noted in renal glomeruli. Measles antigen also are present in liver, spleen and lymph nodes. LaPointe *et al*[37] in a preliminary report of kidney biopsies from seven patients with SSPE, observed that in most cases, glomerular endothelial proliferation is present. In all seven, they note beta 1-C deposits on glomerular basement membranes. Jenis *et al*[38] suggest that complement mediated immune cytolysis is operative in SSPE, based on immuno-ultrastructural localization of immune complexes to intracellular inclusion bodies and plasmalemma of infected brain cells and to the outermost lamellar portion of adjacent myelinated axons. Consequently, viral immune-complexes are a feature of SSPE, but their role in the progressive damage of this illness remains to be established.

VIRUS

Oyanagi *et al*[39] report ultrastructural differences between cells infected with SSPE measles virus isolates and those with conventional measles virus. With wild or Edmunston strains of measles, granular filaments predominate in the cytoplasm beneath the cell membrane and few intranuclear filaments are seen. With SSPE measles virus, large amounts of intranuclear filaments form inclusions and large amounts of cytoplasmic filaments accumulate, but the area under the cell membrane is spared. In another study, Horta-Barbosa *et al*[40] report that cytopathology and plaque formation of SSPE measles showed greater similarities to vaccine strains of virus than to wild measles. This similarity to attenuated virus is of note because a strain which is relatively nonlethal to the host cells may be important in forming a chronic infection.

CELL CULTURE

The features of viral synthesis in SSPE are comparable to Rustigan's experimental model of persistent measles infection of Hela cells.[41, 42] Infected Hela cells in presence of antibody fail to produce infectious virus but synthesize incomplete virus according to Rustigan,[42] even when subsequently cultured in antibody-free medium. The study of Webb *et al*[43] concerning long-term production of two types of measles-vaccine virus inoculated into cultures of human fetal brain also has relevance to SSPE. Infected cells develop focal loss of contact inhibition and proliferate more rapidly than controls. Webb *et al* conjecture that measles virus induces similar glial proliferative changes *in vivo*.

VACCINE

How vaccination affects the incidence of neurologic complications of measles is a crucial problem. Pampiglione *et al*[44] report EEG changes after vaccine in six of eight children. Their preliminary study shows a much higher incidence of EEG changes following measles vaccination than previous studies. They suggest that different types of vaccine or alternatively mild, intercurrent infection may determine the incidence of EEG changes. Landrigan and Witte,[45] from review of data following measles vaccination from 1963 through 1971, report 84 cases with neurologic disorders, a very low incidence of 1.16 case per million doses. Most of the complications are encephalitis or encephalopathy, with only one case of SSPE noted. However, it is possible that more cases of SSPE may subsequently develop. Other cases of SSPE have been reported following measles vaccination.[46] In the registry report,[8] a total of 14 patients received the vaccine prior to developing SSPE; six of these 14 also had measles before the onset of SSPE. Consequently, vaccination does not preclude the development of measles encephalitis or SSPE. Encephalitis following vaccination occurs in a much lower incidence than in natural infection, but data for the comparative incidence of SSPE with attenuated vaccine versus natural infection is not as yet available.

MULTIPLE SCLEROSIS

Brody *et al*[47] report that multiple sclerosis (MS) patients have higher antibody levels to six of 11 viruses tested. Measles is among the six for which higher levels are observed. Furthermore, measles serum antibody levels are more frequently and consistently elevated in MS patients than serum antibody levels to the other viruses examined. Several recent reports[48, 49] suggest active measles antibody production in the CNS of some patients with MS. The data, as yet, do not constitute etiologic proof of an association between measles virus and MS. However, in view of the demyelinating properties of measles virus and the long, dormant period between measles infection and manifest disease in SSPE, the possible role of measles virus in MS deserves careful examination.

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Intrapartum Fetal Deaths

While the skill and judgement of the obstetrician frequently determines the future of the fetus, it is during labor that this is especially true. The number of infants who die during labor is an index of the quality of obstetric care.[1]

This quality has been improved recently by new laboratory techniques, i.e., urinary estriols, lecithin-sphingomyelin ratios of amniotic fluid, ultrasonography and fetal monitoring.

The purpose of this paper is to examine fetal deaths after admission and determine if a better method of management and more efficient utilization of present facilities is possible.

Materials and Methods

This report is based on data obtained from a ten-year study initiated in 1962 at St. Luke's Hospital. Data on every delivery of an infant weighing more than 500 gm during the ten-year period was recorded on a computer to facilitate studies such as the present one.

During this period, there were 21,263 deliveries resulting in 21,486 infants. Four hundred and seventy-five perinatal deaths occurred during this ten-year period with 254 during the first five years and 221 during the second five years. The perinatal mortality rate during the first five-year period was 24 per 1,000 and in the second five-year period was 20 per 1,000. Of these 475 perinatal deaths, 73 were intrapartum fetal deaths. Thirty of these occurred during the first five years for a rate of 2 per 1,000 and 43 occurred during the second five years for a rate of 3 per 1,000. Part of the increase in intrapartum fetal deaths might be explained by an increasing number of clinic patients delivered at St. Luke's Hospital in the second five-year period. In the first five years, the percentage was 2.6% of total deliveries, but in the second five-year period this number increased to 19.7%. During this second five years, intrapartum fetal death rates were 3 per 1,000 for the private patients and 7 per 1,000 for the clinic patients.

In the following figures reported, private, clinic, white and nonwhite patients are grouped collectively: the autopsy percentage for these infants in this series was 93%.

Intrapartum fetal death was determined according to the following criteria: (1) Documentation of fetal heart tones on admission and after onset of labor; (2) Absence of any sign of life after complete delivery of the infant. Fetuses in which the fetal heart tones were doubtful on admission were not considered.

TABLE 1

Cause of Death	*500-1,499 gm*	*1,500-2,499 gm*	*> 2,500 gm*
Interrupted Fetal Circulation			
a) Placenta previa	3	0	0
b) Abruptio placenta	2	7	1
c) Prolapsed cord	0	2	0
d) Miscellaneous (ruptured marginal sinus; ruptured fetal vessels)	4	1	4
Premature ruptured membranes	3	0	2
Erythroblastosis	0	0	3
Congenital anomalies	0	4	3
Toxoplasmosis	0	0	1
	12	14	14
Total	40		
Unknown cause of death	10	6	17
Total	33		

Results

In Table 1, the infants have been divided into three weight groups, 500 gm-1,499 gm, 1,500 gm-2,499 gm and greater than 2,500 gm. In this series of 73 cases, 40 infants died of one or more known causes or 55% of the total. In the first category in Table 1, Interrupted Fetal Circulation, there was a total of 24 infants. In the first group, (a) Placenta Previa, three infants were in the low-weight group, one of which was anencephalic. In the (b) Abruptio Placenta group, there were two in the low-weight group, one of which had an intrauterine device (IUD) in place which was expelled ahead of the fetus at delivery. Seven cases of death occurred in the middle-weight group, one mother was isoimmunized and one case occurred within a few hours following an appendectomy. In the (c) group, two infants died from prolapsed cord. In the (d) Miscellaneous group, four cases of ruptured marginal sinus occurred in the low-weight group and one in the medium-weight group. In the larger-weight group, there was one case of ruptured marginal sinus. In addition, there were three cases of ruptured fetal vessels of a succenturiate lobed placenta and one case of ruptured vasa previa. Five cases of premature ruptured membranes occurred. It has been defined here as ruptured membranes prior to the onset of labor. This category is open to question as a primary cause of death.[2] In this series, however, all infants in this category had either amnionitis, placentitis or pneumonitis at autopsy. There were three infants who succumbed from erythroblastosis and all weighed more than 2,500 gm. One fetal death occurred in 1962, one in 1965 and one in 1970. It should be noted that the first amniocentesis done at St. Luke's Hospital was in 1966. There were seven infants who died with multiple congenital anomalies, five of whom were central nervous system abnormalities. And, finally, in 1965, one case of toxoplasmosis occurred, resulting in fetal death.

In 33 cases or roughly 45% of the series, no single acceptable cause was present to explain fetal death. The distribution was ten in the low-weight group and six in the middle-weight group. In the latter group, one infant had a tight nuchal cord. However, the actual significance of this entity is open to question.[3] One infant's mother had Henoch-Schonlein purpura with subsequent renal failure requiring hemodialysis. Finally, in the larger-weight group, there were 17 cases with unknown cause of death. In one case, an ovarian cystectomy was done at 3½ months gestation; the infant was carried to term without difficulty but died during labor. Three additional cases in this group reportedly had tight nuchal cords at birth.

There are cases included in Table 1 that might have been salvaged, such as the eight infants weighing more than 1,500 gm who died from abruptions, as well as the two with premature ruptured membranes weighing more than 2,500 gm. Even though two cases of fetal death due to erythroblastosis antedated our first amniocentesis at St. Luke's Hospital, it is still questionable why these three infants were not delivered earlier than the gestational ages of 37, 38 and 42 weeks. Then there is the large group of cases in the known-cause group, 23 in all, who weighed more than 1,500 gm. In all, roughly 35 cases were lost that at least might have been followed more closely or possibly some physician's error in management or diagnosis might have been avoided.

Seventy-three cases of intrapartum death occurred in a ten-year retrospective study of 21,486 infants delivered at St. Luke's Hospital. Although the perinatal mortality rate was slightly less during the second five years, causes of death were established in only 40 cases. The study suggests that early identification of the high-risk pregnancy coupled with better utilization of fetal monitoring facilities might be useful in reducing the number of intrapartum fetal deaths. The authors are from the Department of Obstetrics and Gynecology, St. Luke's Hospital.

Table 2 lists some of the other factors which might have contributed to fetal death. There were eight cases of postmaturity established by dates alone, ranging from 42 to 46 weeks.

Eighteen mothers had a history of one or more previous neonatal deaths. Eleven mothers were 35 years old or older. The average age in this series was 26.9 years.

Pre-eclampsia was diagnosed in 12 cases with none recorded as severe. There were three diabetics, and three mothers had no prenatal care. All three of the latter were clinic patients.

Meconium staining of the amniotic fluid, which frequently has been discussed as an indication of fetal distress,[4–6] was present in 16 cases.

On reviewing Table 2, one finds a large number of complications present in a relatively small number of patients. Retrospectively, these were all high-risk patients and many of them went unrecognized.

There have been 27 cases of intrapartum fetal deaths since January, 1970, when fetal monitoring

TABLE 2

CONTRIBUTING FACTORS

Factor	*500-1,499 gm*	*1,500-2,499 gm*	*> 2,500 gm*
Gestation > 42 weeks	0	0	8
Previous neonatal deaths	6	6	6
Maternal age > 35 years	2	3	6
Pre-eclampsia	2	5	5
Diabetes	1	1	1
No prenatal care	2	1	0
Meconium stained fluids	0	6	10

equipment became available at St. Luke's Hospital. Eighteen of these weighed more than 1,500 gm. The fetal monitor was utilized on only six of these cases. In two instances, it confirmed fetal death. In one case, fetal death occurred from ruptured fetal vessels before a C-section could be done. In one case, fetal death occurred despite warning of uteroplacental insufficiency by the monitor.

Because of obvious prematurity in several cases, it was decided that a heroic effort was futile, but such a decision is open to considerable question.

In Table 3, the timing of fetal death as related to cervical dilatation is listed. The break at 3 cm was arbitrarily designated because this is about the earliest point at which application of the internal monitor is feasible. The monitor, according to this criteria, could have been applied in 30 cases of salvageable infants weighing more than 1,500 gm; there were 11 in the medium-weight group and 19 in the larger-weight group. As external monitoring techniques become more reliable, there should be no reason not to have continuous fetal monitoring during labor, including the very early stages. External monitoring during very early labor could be the key in selecting previously undiagnosed high risk patients. If any abnormality occurred in the pattern obtained from the external monitor or other clinical factors warranted it, the internal monitor could then be applied as soon as possible.

TABLE 3

TIMING OF FETAL DEATH ACCORDING TO CERVICAL DILITATION

500-1,499 gm		*1,500-2,499 gm*		*2,500 gm*	
< 3 cm	> 3 cm	< 3 cm	> 3 cm	< 3 cm	> 3 cm
8	14	8	11	13	19

Discussion

Intrapartum fetal death, especially in the higher-weight infant, should be an area of perinatal mortality we could improve more easily as better fetal monitoring aids become more widely accepted. Much of the decline in perinatal death ten to 15 years ago was due to a decrease in the number of infants dying during labor. More recently, however, intensive care of the newborn, especially the premature newborn, has decreased markedly neonatal mortality and morbidity. It would now seem appropriate to take a second look at intrapartum death to see if even further improvement is possible in this area of perinatal medicine.

Lilien[7] reported 83 cases of term intrapartum fetal death from 245 term fetal deaths in 1970. An acceptable explanation for death was present in 43 of these cases. The most frequent causes were prolapsed cord, abruptio placentae, hydrocephalus and uterine rupture. Of the 40 remaining cases, no cause of death was established. He compared selected obstetric conditions to a control group in which breech presentation, tight nuchal cord, premature rupture of membranes, prolonged gestation and history of prior stillbirths were found to be significant in the diagnosis of high risk pregnancy.

Stern[8] reported on 57 intrapartum fetal deaths of 1,000 gm or more in 1960. He stressed that closer attention and awareness of the signs of fetal distress and good judgment in the selection of the time and type of interference in the difficult or abnormal labor would do much to reduce the number of infants dying during labor.

The World Health Organization Expert Committee on the Prevention of Perinatal Mortality and Morbidity[9] recommends that recognition of the high risk pregnancy based on health, social status and past obstetrical history be made at the first prenatal visit. Additional patients are added to this group as secondary factors become evident, i.e., pre-eclampsia, maternal infections and other causes. The patient should then be thoroughly reevaluated at some point in later pregnancy, ideally at approximately 28 weeks. This high-risk fetus should then be delivered in the best available invironment with optimum support during labor, adequate monitoring equipment, facilities for immediate C-section and an available neonatal intensive care unit. An obstetrician, anesthesiologist and pediatrician should be in attendance, and their close cooperation in this area is a must. The diagnosis of the high-risk pregnancy is of utmost importance so that one can decide in the future who is to be delivered in this intensive care environment and who is to be delivered possibly by a midwife. With our ever-increasing sophistication of monitoring equipment and techniques, a quotation of Dr. Irving of Boston Lying-In Hospital might well be remembered: "A woman does not come to the Lying-In Hospital to go through a case of pregnancy; she comes to take home a baby." If she loses the baby, it does not matter to her whether death occurred before, during or after labor.[10] Our techniques of monitoring, especially during labor, can help us to assure the gravid patient that she will

(Continued on page 235)

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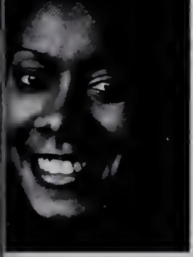

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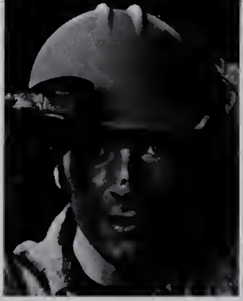

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gastritis

The patient
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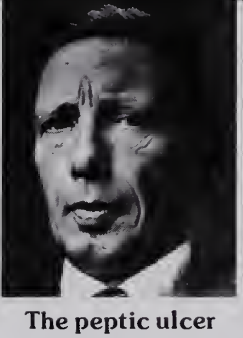

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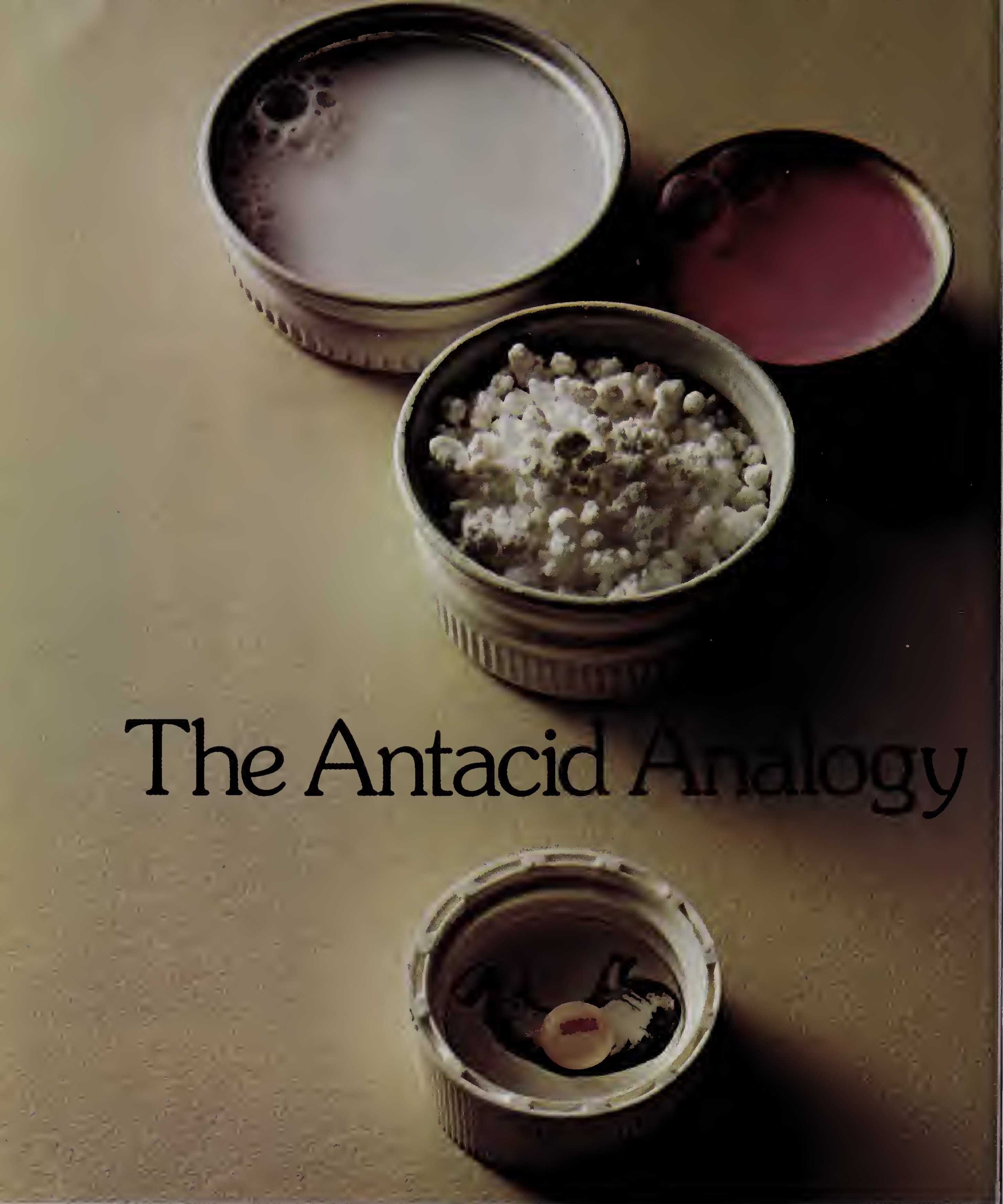

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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GILBERT N. LASSER, M.D., ***St. Louis***

Low Back Syndrome and Inguinal Hernia

At first glance, the low back syndrome and inguinal hernia may appear to have little in common. When the conditions coexist, however, there may be considerable confusion in diagnosis and treatment. Pain and tenderness in an inguinal hernia may be related to the hernia itself or to complications such as incarceration or strangulation. However, the pain in the groin may emanate from a variety of low back conditions which includes acute and chronic lumbosacral sprain, arthritis, spondylolisthesis and intervertebral disc disease. All of these conditions share a similar pain pattern and pain reference to the buttocks, legs or groin. For simplicity, they have been lumped together as "the low back syndrome." Peculiarly, most text books or articles on the symptomatology of the low back syndrome include the usual reference of pain to the leg, buttock or hip but omit or are vague about reference of pain to the groin. In a monograph on the intervertebral disc, DePalma's[1] only mention of pain in the groin associated with lumbar disc disease in the lumbar region is that there is confusion about it. Kopell[2] recognizes groin pain secondary to low back conditions and explains that it is due to entrapment of the ilioinguinal nerve. None of the standard monographs on hernia even mention low back conditions in the differential diagnosis of pain in the groin.

In order to appreciate the frequency of pain in the groin secondary to low back derangements, 1,000 consecutive cases of "low back syndrome" during a span of ten years have been reviewed. Most of these represent cases of patients in industrial accidents who have been seen immediately after an injury, and a large portion of these injuries can be termed acute lumbosacral sprains. Chronic and recurrent back conditions have been lumped together and include chronic lumbosacral sprains, chronic hypertrophic arthritis, spondylosis, spondylolisthesis and herniated lumbar discs. Of these, 588 could be classified as acute and 412 as chronic or recurrent. In 138 cases (14%), there was pain to the leg, and in 118 cases (11.8%) there were references of pain to the groin. Approximately one half were found in the acute cases and the other half in the chronic or recurrent cases. Eleven of the patients who had pain stemming from the groin also had groin hernias. Two of these existed before the back conditions and the remainder allegedly manifested themselves at the same time (Fig. 1).

Case Reports

Case # 1. A 29-year-old man was seen in the office following an episode of lifting at work. The patient came in complaining of extreme pain in the right groin and the presence of a mass which he stated had not been present previously. On examination, the patient was found to have a moderate sized, incarcerated right inguinal hernia which was exquisitely tender to pressure. The hernia could not be reduced. Because of marked tenderness, he was hospitalized and operated on the same day for a possible strangulated hernia. At surgery, the hernia sac was found to be thick-walled. The contents of the sac was omentum, which was held to the wall of the sac with dense adhesions. It was obvious that the hernia had been present for a long time. There was no evidence of any strangulation of tissue to account for the marked tenderness found on original examination. The hernia was repaired without difficulty. However, immediately after the operation, the patient continued to complain of pain in the groin. It was not until the following day that the patient stated that he also had some pain in the back. A trigger point was located in the right paravertebral area about the level of L_5. Injection with 5 cc of 2% xylocaine in this area gave the patient immediate relief of symptoms. It then

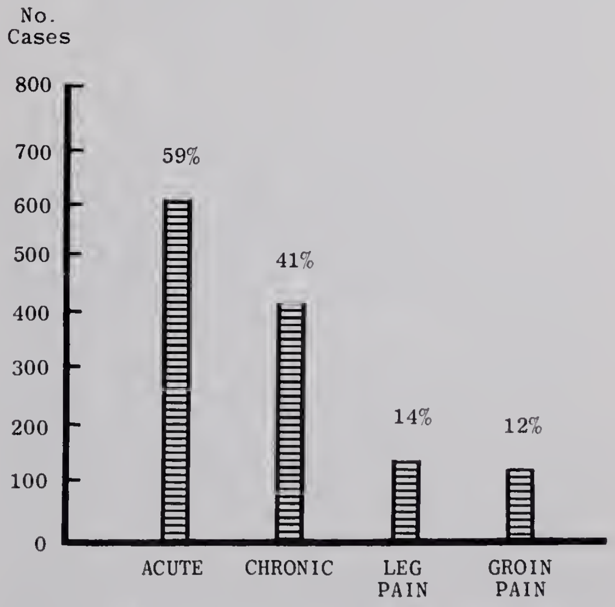

Fig. 1. Pain radiation in 1,000 patients with low back syndrome.

If an inguinal hernia coexists with a low back syndrome, it may be extremely difficult to differentiate the source of the pain in the groin. This differentiation becomes important not only from a medical-legal aspect, but also from the standpoint of prognosis and instituting proper therapy. Dr. Lassar is from the Jewish Hospital of St. Louis.

became obvious that the patient's symptoms were secondary to a lumbosacral derangement with pain referred to the right groin. The hernia was of long standing and in no way related to the acute episode. The patient made a good recovery, but continued to have some back pain. He was treated conservatively and was able to resume work in about seven weeks.

Patient # 1 presented with a diagnosis of pain in the groin. The patient and the surgeon both felt that the hernia was the cause of the pain. In retrospect, it was obvious that the pain and tenderness were from the back disease which previously had not been recognized. Although the patient stated that the lump in the groin had not been present previously, it was later demonstrated by the thickness of the hernia sac and dense adhesions that it must have been of long standing. Does this mean that the patient was falsifying the history? Not necessarily. Many individuals are walking around with hernias unaware that they exist. If one's attention is directed to the groin by a sudden pain, however, he may notice for the first time that a lump is present.

Case # 2. A 16-year-old man stated that he slipped on a hose while at work. As he fell, he felt a sharp pain in the left groin and noted a large mass present. On examination, the patient was found to have a moderate size, left inguinal hernia which was easily reducible. There was a slight tenderness. The patient stated that the hernia had not been present previously. Examination of the back was essentially negative, and the patient denied previous back difficulty. He was hospitalized, and a left inguinal herniorrhaphy was performed. The patient made an uneventful recovery, but about three weeks after the operation, he complained of pain in the back which radiated to the groin and gave him the same type of pain as he had had prior to the operation. A regimen of phenylbutazone (Butazolidin) was started and gave him relief of the symptoms so that he was able to resume work seven weeks after surgery.

In this instance, the patient had no back symptoms or findings until three weeks after surgery was performed. The question of compensability becomes an issue in some cases. Under the Missouri Workmen's Compensation Law, Paragraph 287.195 states, "In all claims for compensation for hernia resulting from injury arising out of and in the course of employment, it must be definitely proved to the satisfaction of the Commission: 1. that there was an accident or unusual strain resulting in hernia, 2. that the hernia appeared suddenly accompanied by intense pain, 3. that the hernia did not exist prior to the accident or unusual strain, 4. that the hernia did not exist prior to the accident or unusual strain resulting in the injury for which compensation is claimed." Inasmuch as the pain in the groin originated from a low back syndrome rather that from hernia, it was our opinion that the latter could not be considered compensable.

Case # 3. A 55-year-old man came to the office because of severe pain in the left groin. The patient stated that on the previous day, he was lifting a refrigerator onto the back of a truck when he suddenly felt a sharp pain which radiated to the right groin. Shortly afterward, the patient felt a tender mass in the right groin. On further questioning, the patient stated that the pain seemed to radiate from the region of the anterior superior spine down to the right testicle. On examination, the patient appeared to be in acute distress. He was unable to sit and had extreme difficulty in walking because of the pain. A mass which was easily recognized in the right femoral region, was exquisitely tender to palpation. The tenderness, however, extended up above the anterior superior spine and around to the lower back. A trigger point was located in the right paravertebral area at the level of L_5. Pressure over this area reproduced the pain in the groin. The hernia was easily reduced. The trigger area was injected with 5 cc of xylocaine with dramatic relief of the patient's symptoms. Two weeks later, the patient was operated on for a hernia. Following the operation, the patient again complained of the severe pain in the groin which had been present previously. It was noted at this time that there was hyperesthesia of the skin over the inguinal region. The trigger area of the right paravertebral area was again injected with 5 cc of xylocaine with immediate relief of symptoms.

Discussion

Difficulty arises when one attempts to explain the reference of the pain to the groin from an injury in the lumbosacral area. Usually, pain originating at this level (L_4-S_1) is referred to the buttock, hip or down the leg while pain in the groin is referred from L_1-L_2. This confusion is probably the result of comparing "apples to oranges." Actually, there are two distinct types of referred pain. The pain arising from tears of ligaments, periosteum and muscle differs from actual stimulation of a nerve root. DePalma[1] refers to the former as scleratogenous (diffuse pain) and the latter as dermatogenous (specific pain). Inman and Saunders[3] (1944) have attempted a systematic presentation to show the nerve supply of superficial and deep muscles, and they have coined the term scleratome for the zone of deep tissues innervated by a given spinal segment. Kellgren[4] (1939) injected 6% saline into various muscles and plotted the segmental distribution of pain. In accord with these articles, it becomes apparent that the ligaments, muscles and fascia at the level of L_5 and S_1 are actually innervated by nerves arising from the posterior rami of

L_1-L_2. Therefore, if there is a tear or spasm of the myoligamentous structures at the lumbosacral level, the pain would be referred to the groin. On the other hand, if the injury is of such a nature that there is irritation of the nerve root, such as one would get from a bony ossicle or herniated disc, the distribution would extend down the leg. Also of interest is the character of the pain in Cases # 1 and # 3. In these two cases, the pain was intense and was accompanied by hyperesthesia of the skin, suggesting actual nerve irritation. DePalma[1] describes two types of dermatogenous pain: (1) sharp and localized to a cutaneous area and (2) slow pain which is dull and aching in character with no clear localization. Kopell[2, 5] describes this type of pain radiation and feels that it represents entrapment of the ilioinguinal nerve as it emerges through the transversus and internal oblique muscles near the anterior superior iliac spine.

Actually, most hernias are not painful unless they are recently incarcerated or strangulated. Zimmerman[6] feels that the so-called acute hernia may be associated with a fair degree of pain, but it is usually transient. Hernias usually give symptoms of dragging or heaviness but are not usually severe enough to incapacitate an individual. If a patient says he is unable to work because of the severity of the pain, one should look for other causes.

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Intrapartum Fetal Deaths

(Continued from page 232)

receive a baby that has not been compromised during labor.

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Hepatojejunal Anastomosis in Management of Traumatic Intrahepatic-Cutaneous Biliary Fistula

Case Report

THE MANAGEMENT of blunt hepatic trauma, an increasingly frequent encounter, is often a multifaceted challenge of considerable magnitude. With nearly 50% of the mortality due to massive exsanguination, control of hemorrhage becomes the first priority. Almost 10% of patients will require a partial hepatectomy.

The purpose of this paper is not to dwell on the technique of liver resection and control of hemorrhage in liver trauma, but to detail a unique method of successful management of a delayed complication of the injury—that of a persistant colangio-cutaneous fistula arising from near the dome of the right lobe of the liver. Although biliary fistulae from the common bile duct are sometimes difficult to successfully close and broncho-biliary fistulae may be life threatening, the rupture of a major intrahepatic duct with resultant biliary-cutaneous fistula presents with few guidelines in the literature in regard to its proper handling.

CASE REPORT

A 29-year-old white man was referred to the University of Missouri Medical Center on Aug. 5, 1973 after having been involved in an automobile accident on July 19. He was referred to the Medical Center for the management of a persistent biliary fistula. The patient had sustained massive liver injury with the left lobe of the liver almost avulsed from the vena cava. A thoracoabdominal incision was required to obtain adequate control of the vena caval and hepatic vein lacerations. Multiple transfusions were required to retrieve the patient from a near pulseless state. In addition to the left hepatectomy, considerable debridement of devascularized fragments of the right lobe was required. Postoperatively, a persistant biliary fistula developed. A subphrenic abscess was drained on the 15th postoperative day. The serum bilirubin level gradually fell from a high of 8.6 mg/100 ml to a near normal range.

Following admission to the University of Missouri Medical Center, attempts were made to define the nature of the fistula. Fig. 1 shows a fistulogram filling the common bile duct and duodenum via a fistula from the defect in the liver. On December 9, reexploration of the abdomen revealed a considerable suprahepatic and subdiaphragmatic collection of bile. An insertion of a T-tube for decompression purposes was unsuccessful in diverting the bile drainage, and the patient was returned to the operating room on December 26. The long limb of the T-tube was passed up the right hepatic duct to a point within the liver which had been lacerated at the time of the initial trauma. By placing the operator's index finger in the lemon-size conical defect near the superior surface of the liver (Fig. 2), the cholangiogram dye could be diverted into the smaller radicals of the right lobe. After this de-

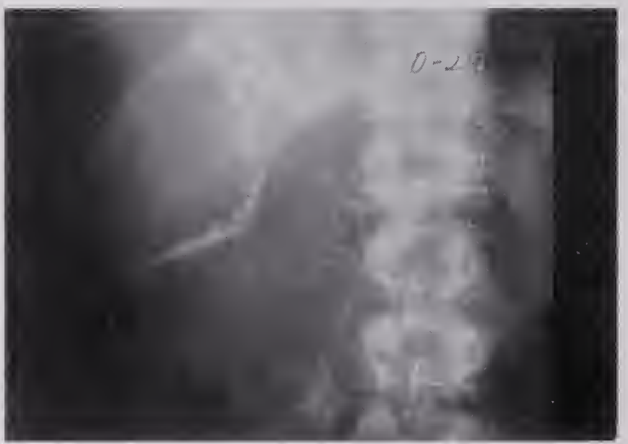

Fig. 1 Injection through external fistula showing filling of triangular shaped suprahepatic collection, common bile duct and duodenum.

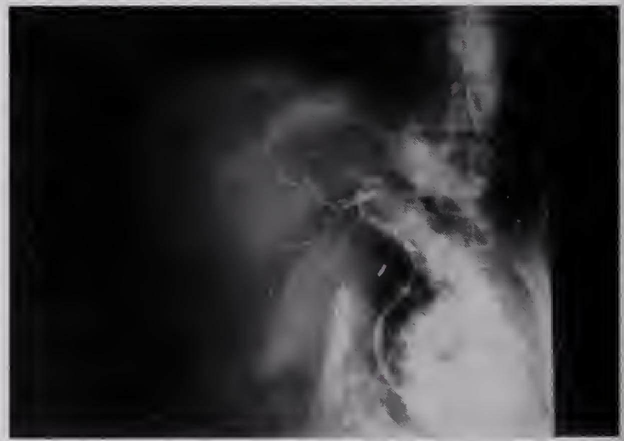

Fig. 2 Intraoperative cholangiogram via straight tube into common duct. Dye fills hepatic radicals as leak is occluded by surgeon's finger.

termination, a Roux-en-Y jejunal loop was sutured to the scarred fibrous-like ring about the defect of the liver using 000 Tevdek sutures. The long arm of the T-tube was then moved on up beyond the anastomosis and about six inches within the jejunum. Multiple openings in the long arm of the T-tube were made at the level of the right hepatic duct transection. Postoperatively, the fistula ceased draining cutaneously and, instead, drained via the T-tube into the duodenum and jejunum. The patient was discharged with a serum bilirubin level of 0.5 mg/100 ml on the 12th postoperative day. He has continued to do well.

Discussion

The patient sustaining severe hepatic injury, frequently as a result of an automobile accident, presents numerous problems in management. While multiple organ system injuries may be present, those related to the liver alone are often of great magnitude. As in this patient, the major initial concern was that of resuscitation after massive exsanguination. Large tears in hepatic veins and the vena cava required immediate suturing.

At the initial exploration, the proper decision must be made regarding the amount of liver to be debrided or resected. Several excellent publications describe technical considerations required for hepatic resection in such instances.[1-7] The danger of leaving necrotic liver tissue is well recognized because of the danger of delayed hemorrhage. In addition, wound infection, subhepatic and subdiaphragmatic abscess and hepatic decompensation may be encountered. As in this case, the intrahepatic rupture of the remaining major hepatic duct created a persistent cutaneous fistula whose control posed a major problem. Extrahepatic ductal injuries can be repaired by primary anastomosis, choledochoduodenostomy or choledochojejunostomy. A small intrahepatic duct laceration may be treated by ligation of the involved duct.

Complications of blunt hepatic trauma may include the need for management of severed major intrahepatic ducts with persistent and perfuse draining of a bile fistula. The literature, however, presents few guidelines for its proper handling. A hepatojejunal anastomosis is described as a means of diverting bile flow back into the small bowel. The authors are from the Department of Surgery, University of Missouri School of Medicine.

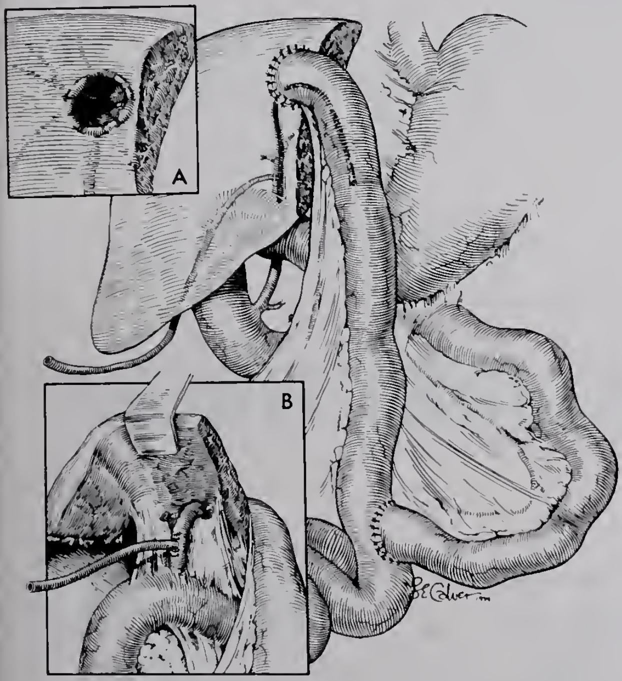

Fig. 3 Artists conception of completed Roux-en-Y hepatojejunostomy with T-tube in common bile duct and extending to skin. (A) Defect in dome of liver with scarred rim. (B) Ligated left hepatic duct ligated cystic duct and T-tube position.

In this case, it was elected to delay final surgery until a firm fibrotic rim about the fistula might be encountered. At operation, the previously described cholangiogram showed no dilated hepatic ducts, signifying no stenosis at the area of injury. An internal drainage of the fistula was accomplished via an antecolic Roux-en-Y jejunal anastomosis to the large defect over the diaphragmatic surface of the remaining liver lobe (Fig. 3).

Summary

Massive liver injuries may require partial hepatic resection to control life-threatening, immediate hemorrhage and delayed necrosis with subsequent bleeding. Additional complications of the trauma may include the need for management of severed major intrahepatic ducts with persistent and perfuse draining of a bile fistula. A hepatojejunal anastomosis is described as a means of diverting bile flow back into small bowel.

Acknowledgement: The authors wish to acknowledge the case report of the successful intral partial hepotectomy and control of hemorrhage managed by William R. Cole, M.D. of Sedalia.

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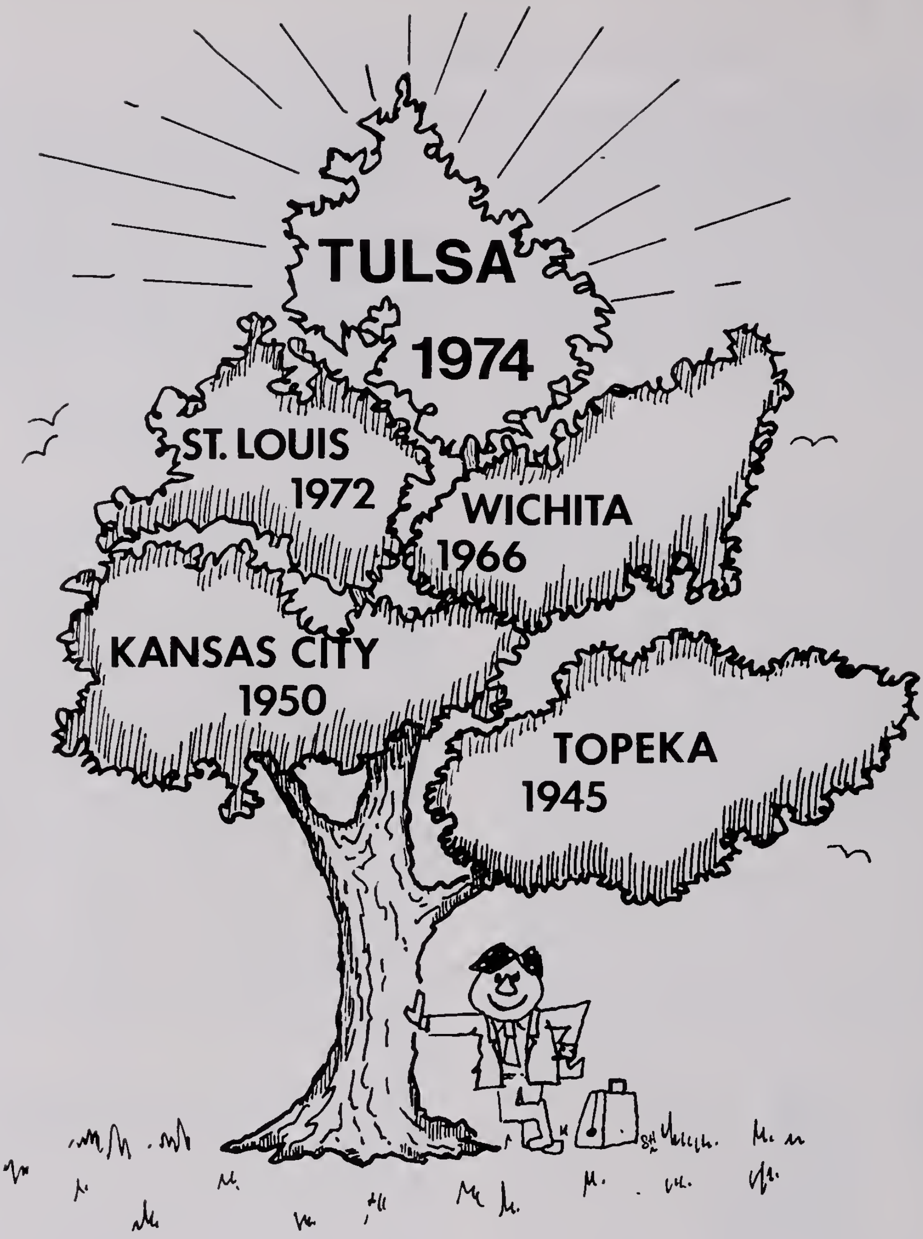

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YOUR INDEPENDENT SURGICAL SUPPLY DEALER

President's Message

The 116th Annual Session of the House of Delegates has become history. The actions taken by that House brighten the future of the MSMA.

This House funded continuing medical education for Missouri. A truly great program is now possible. With Dr. Paul Young at the helm, it will develop rapidly.

The delegates approved a plan of communication that will bring closer and better understanding among members of the MSMA. The Association will have two Field Secretaries who will work with, learn from and help the county societies. The goal of our Field Secretaries will be to visit every physician in the state at least twice a year.

The MSMA staff has been directed to develop a professional liability program. These plans are well advanced.

A service organization is to be developed to meet the specific needs of Missouri physicians. The benefits of the program will be available to all members of the MSMA, but it might be interesting to see what the proposed program would do for a young physician just starting in practice.

James C. Cope, M.D.

This young physician would be met by one of the Field Secretaries, who would help him understand the Medical Association, its aims and advantages. The Field Secretary would help him plan his malpractice insurance coverage. He would be able to participate in a group life insurance plan, secure income protection and have major medical coverage through his Medical Association. He could lease-buy an automobile or insure his own automobile through an Association-sponsored plan.

Opportunity for continuing medical education would help the young physician stay abreast of medical advances. He would be kept informed of changes in state and federal regulations by frequent contact with his Field Secretary. He could join a medical care foundation sponsored by his Society.

Through the MMPAC, the young physician would have the opportunity to work with other physicians for good government.

Such a program will not emerge overnight or even this year, but the course has been charted and the sail has been set. We are under way.

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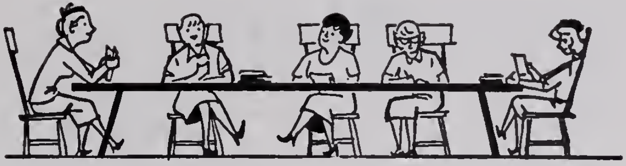
Woman's Auxiliary



"It is better to light one small candle than to curse the darkness," according to an old Chinese proverb. This will be the theme of the 1974-1975 year of the Woman's Auxiliary to the Missouri State Medical Association.

During the war, a show being given at a football stadium was interrupted, and all lights were extinguished. Each member of the audience was asked to light a match. The ensuing brightness was truly amazing. This small example demonstrates the increased power of individuals working together. It is the hope of the Auxiliary that we can achieve greater things through greater individual effort in the coming year.

*

"The King is dead—long live the King!" has always signified the changing of leadership. As incoming President, it is my hope that we will continue to progress in achieving our objectives as boosters of organized medicine and health care.

The smoothness of the transition is due to the outgoing President, Mrs. Charles R. Willman of St. Joseph. She has been not only an outstanding President but, also, a patient and understanding teacher. It has been a privilege to work with her.

Mrs. George J. Lytton
President

*

If, in the coming year, each member can "light one small candle," perhaps there will be no need to "curse the darkness."

EDITORIAL

HEALTH CARE COSTS

Congressional leaders have placed heavy emphasis on passing a multi-billion dollar forced national health insurance program this year.

Sen. Edward M. (Ted) Kennedy, D-Mass., and Rep. Wilbur D. Mills, D-Ark., proponents of opposing views, have agreed on a compromise bill with less government participation than Kennedy previously had insisted on and more than Mills had favored.

Kennedy wants to sweep all medical care for Americans into the embrace of federal bureaucrats.

The $40 billion cost of the scheme would be financed through increased Social Security taxes. This comes at a time when existing Social Security taxes are becoming oppressive. Many Americans already pay more Social Security taxes than income taxes.

Kennedy's original $80 billion plan has been scaled down in the compromise. But it is still compulsory.

The new plan falls within the huge $40 billion estimate for a Comprehensive Health Insurance Plan (CHIP) proposed last February by President Nixon.

President Nixon also has made compromises toward a more federalized approach to health care problems.

It now appears the President and Kennedy are close together on this issue. Nixon's bending toward compulsory national health has had the earmarks of a rear-guard action.

Pressure from Congress to federalize health insurance prompted the Administration to find some formula for filling gaps in the present insurance system. The reasoning grows that unless Congress accepts the President's limited intrusion of government into the way we provide for our health care then we will have to accept a much greater one.

Kennedy, for the time being, is settling for one bite when he still has his eye on the whole cookie.

The AFL-CIO, providing the support for Kennedy's original plan, is lukewarm toward the compromise proposal. Its treasury is bulging with funds to support congressional candidates who might make the next Congress veto proof and pro-labor enough to buy the original Kennedy plan, which was the brainchild of the late Walter Reuther.

Both the Kennedy-Mills plan and the President's CHIP proposal will mean higher payroll deductions for three out of four Americans already covered by group health insurance.

Bringing poor risks and more people into insurance plans and spreading out the cost is virtually certain to increase the cost to the nation's workers.

Medical costs in general began their steepest climb when the government assumed responsibility for the health care of the poor and the aged through Medicaid and Medicare.

If Congress puts the entire nation into the federal bureaucratic system, then we may be looking back at today's medical bills as a bargain.

—Jefferson City Post-Tribune
April 17, 1974

LETTERS to the Editor

To the Editor:

Re: "Your Behavior and Cancer" by John S. Spratt, Jr., M.D. (Missouri Medicine, Vol. 71, No. 1)

I trust that my comments on the article, "Your Behavior and Cancer," will not be construed in any way as critical of Dr. Spratt personally. I have the greatest respect for Dr. Spratt and his accomplishments are of volume and quality which make disagreement difficult. However, the reading of this article convinces me that it would be in the very worst interests of the general public that it be widely disseminated outside the medical profession. Even its publication in Missouri Medicine portends ominous difficulties for physicians in Missouri.

Dr. Spratt realizes, I am sure, as do all of us the enormous variation in the degree of certainty connecting the various items he enumerates with carcinogenesis. Indeed, at least a few have now been relatively completely exonerated in this situation.

No such discrimination is possible with an unsophisticated public and is extremely unlikely in the case of a sensation-seeking press. I predict that within a month in some publications will appear the scare headline, "Prominent Cancer Doctor states that such-and-such causes cause cancer," and the such-and-such will be one of the things in this article which may or may not have been implicated with any degree of certainty as being a carcinogen. In the mind of the reader, only a few facts will stand out. Coffee causes cancer, saccharine causes cancer, beef and sugar and literally hundreds of other things cause cancer and, therefore, must be avoided; not limited, but avoided. It does not seem possible to convince people that what may be helpful in moderation may be harmful in excess. They simply do not react properly to that statement nor do they apply the principle in their daily lives. The result will be anxiety, confusion and, eventually, guilt when they finally find that they must ignore these multiple strictures due to the vagaries and necessities of daily life.

Dr. Spratt's dietary suggestions are, in general, unexceptionable except possibly to those who are concerned with heart disease rather than with cancer and who have somewhat better evidence that dietary intake is directly related to the condition which concerns them. While I am as much in favor of good nutrition and good general health as Dr. Spratt, it would seem to me counter-productive to encourage such measures by holding forth promises of results very unlikely to be accomplished or threats which will serve no purpose other than terrifying an already terrified public.

I am quite aware that Dr. Spratt disavows scientific certainty in regard to many of the factors he discusses in that these protestations are scattered throughout the article. I submit that they will have no effect and will be totally disregarded by general readers who will see only that thousands of environmental artifacts have been implicated at one time or another as being instrumental in the production of cancer in human beings. Surely, it would be better to direct our patients' energies to the avoidance of such unquestioned carcinogens as cigarette smoking and excessive suntanning and avoid involving them in our as yet only tentative investigations of the multiple other factors mentioned in this article.

Sincerely yours,
Thomas J. Weiler, M.D.
St. Louis

The above letter was referred to Dr. John S. Spratt, who offers the following reply:

To the Editor:

Thanks for your note of February 18, sending a copy of Dr. Weiler's commentary on "Your Behavior and Cancer."

As Dr. Weiler correctly points out, the avoidance of cancer through behavior modification is a very complicated issue. However, the literature in recent years has really come up with some very significant observations regarding the causation of cancer. The number of variables involved is quite great and spans the whole spectrum of human activity all the way from a high level of metabolic predisposition to weak carcinogens to excessive exposure of resistant populations to highly potent carcinogens. We have compiled over the years a very comprehensive bibliography on the subject and the National Cancer Institute issues monthly a publication referred to as *Carcinogenesis Abstracts*. Many of the studies are soundly done and it is only the more convincing among them that we used in compiling the article in Missouri Medicine. The grist is already in the scientific journals for the sensational writer to use if he sees fit to do so. Most students of this complicated subject support the point of view that the prevention of cancer involves very extensive behavior modification affecting many aspects of contemporary living patterns.

Dr. Weiler's reaction to this article is, to date, part of a spectrum of reactions ranging from strong approval to extreme disapproval. As indicated in the editorial insert, the readers were specifically requested to comment on it and I hope more feedback will be forthcoming. The article has not actually been distributed to the lay public at this time. To reiterate, nothing is contained in the article for which there is not a study that has already been published in an ethical scientific journal. For the interest of the reader, several additional references including several excellent review articles on chemical carcinogenesis in man are provided below. Also, the effect of extensive behavior modification on the economics of the rest of society cannot be ignored, as a recent commentary in *Fortune* stressed.[1]

It is interesting to note that the Missouri Division of the American Cancer Society underwent a very thorough audit on its activities last year. The audit identified a deficiency in effective public education in this state. We found the same problem with respect to our survey of cancer-control program needs in the state.[2] A more concerted effort at disease prevention through more effective health education and studied approaches toward favorable behavior modification in the interests of health maintenance are unquestionably necessary. As Dr. Weiler correctly points out, such programs can make things worse by creating guilt feelings and other unanticipated psychological reactions. The unbelievably complicated social and psychological web that surrounds the whole cancer problem was reviewed several years ago *(Behavioral Sciences and Cancer)*.[3] This review identified some of the guilt and denial patterns in people that have often made seemingly logical educational programs backfire. It is in the interest of avoiding this last problem that this article was initially published in Missouri Medicine and that the medical profession was asked to critique it. I sincerely hope that the other physicians will provide us with a similarly lucid critique. All of these will be taken into consideration and studied in great detail before any specific program is actually implemented.

Thank you for the opportunity to comment on Dr. Weiler's thoughtful and useful letter.

Sincerely,
John S. Spratt, Jr., M.D.
Director
Cancer Research Center
Columbia

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(Continued on page 251)

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Grand River Medical Society

The March meeting of the Grand River Medical Society was held at the Strand Hotel in Chillicothe. Fifteen members and their ladies attended.

The scientific program was provided by John E. Kooiker, M.D., Professor of Psychiatry, University of Indiana School of Medicine.

The Woman's Auxiliary prepared the red carnation table decorations in celebration of Doctor's Day.

It was voted to hold the next meeting on April 11.

George Mandler, M.D., *Secretary*

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D., POPLAR BLUFF

Mineral Area Medical Society

The Mineral Area Medical Society held a brief business meeting after the Annual Medical-Legal Banquet held at the St. Francois Country Club on March 8.

Mr. Charles Gray of St. Louis, a prominent trial attorney and Lead Belt native, was the featured speaker. His subject was "Certain Dimensions of Medical Liability."

The business meeting was conducted by the President, Dr. Norma Farmer. Dr. Charles H. Appleberry, chairman of the Credentials Committee, reported that the committee had evaluated four applications for membership. On motion by Dr. Appleberry, seconded by Dr. C. W. Chastain, the following new members were voted unanimously into the Mineral Area Medical Society: George W. Dent, M.D., Robert C. Hoye, M.D., George B. Neukom, M.D. and J. F. Tuttle, M.D., all of Farmington.

Members present were Drs. Farmer, Chastain, Appleberry, Metin Arat, Jack Mullen, W. Paul Dennis, Robert A. Huckstep, Charles E. Carelton, Jr., George A. Oliver, A. R. Rao, Javier Pichardo and Carlos J. Borromeo.

C. W. Chastain, M.D., *Secretary*

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Continuing Education Coming Events

May 15-16	**1974 Spring Clinical Conference: Fundamental Cardiology** Continuing Medical Education M.U. Medical Center, Columbia
May 17-18	**Course in Medicine and Surgery** The Jewish Hospital and Washington U. School of Medicine The Jewish Hospital of St. Louis, St. Louis
May 23	**Region VII Conference on Hypertension** Public Health Service Phillips House, Kansas City
May 23	**Abortion: Decisions for Health Care Professionals** St. Louis U. School of Medicine Sesquicentennial Room, Busch Memorial Center, St. Louis
May 23-24	**Symposium: Mild and Moderate Hypertension** Washington U. School of Medicine Continuing Medical Education Stouffer's Riverfront Inn, St. Louis
May 24	**12th Annual Pediatric Seminar: Pediatric Endocrinology** Baptist Memorial Hospital, Kansas City
June 3-4	**Third International Symposium on Intestinal Microecology** Continuing Medical Education M.U. Medical Center, Columbia

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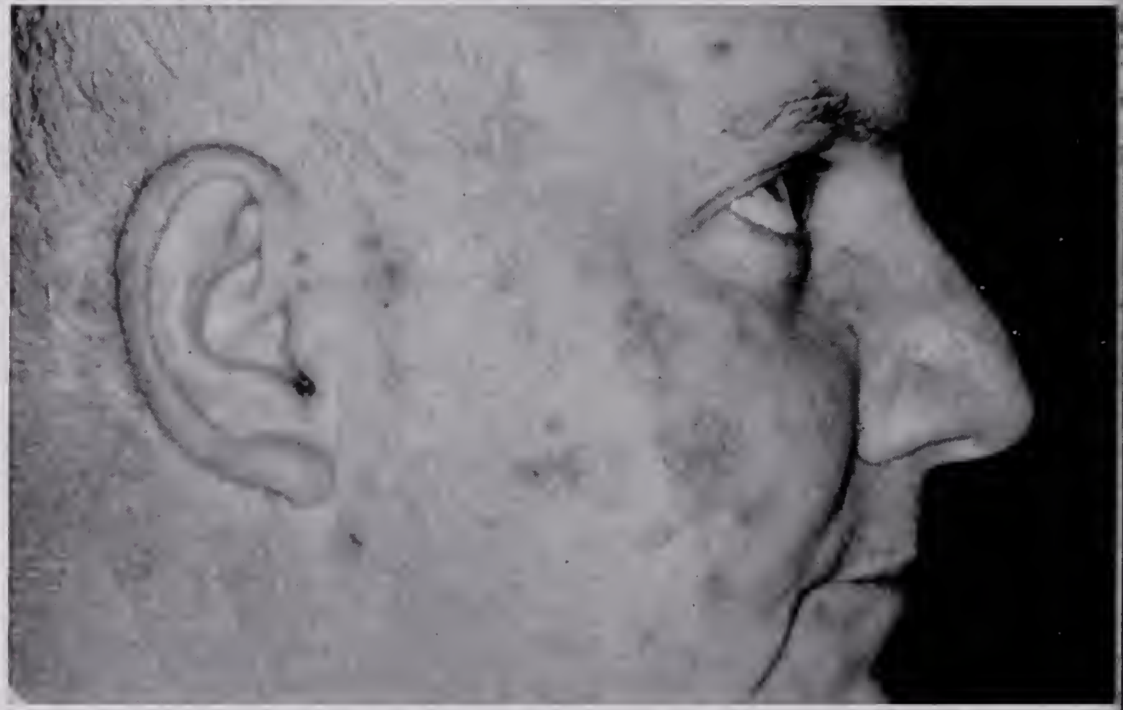
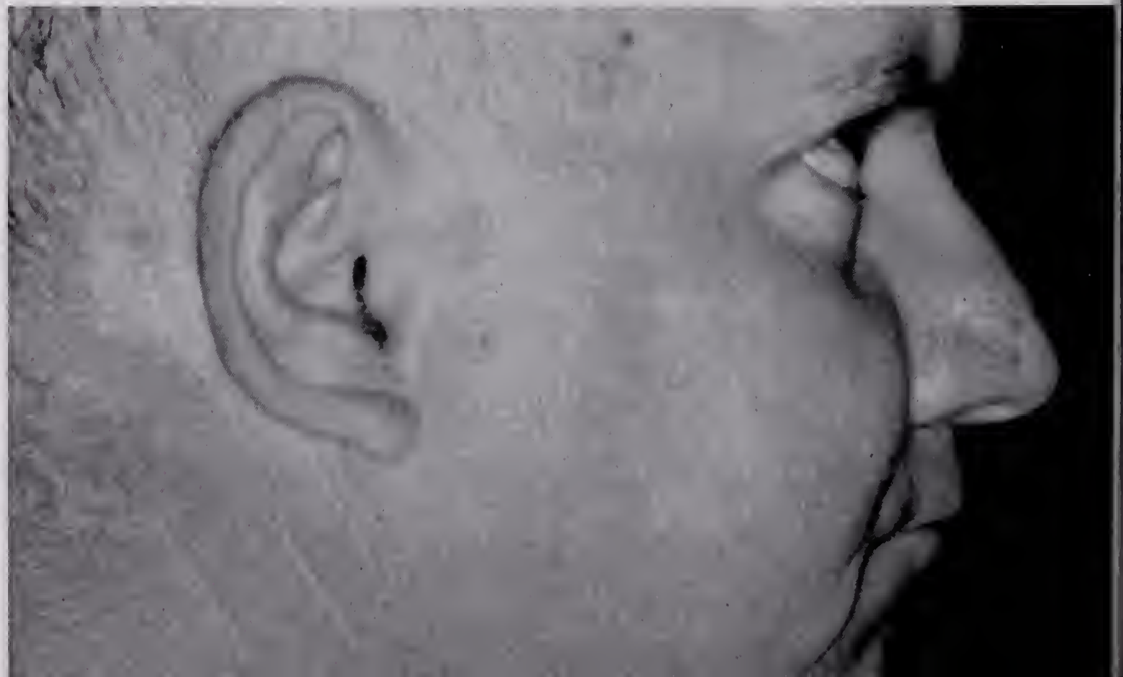
What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.



*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic– so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

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Indications: Multiple actinic or solar keratoses.

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Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

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RICHARDSON K. NOBACK, M.D., Dean

University of Missouri-Kansas City School of Medicine

Progress Report

Since this is the first report from the University of Missouri-Kansas City (UMKC) School of Medicine to appear in this Journal this year, it begins with a short summary of progress to date. This is followed by some comments about the family practice preceptorship program that occurs for all students early in their medical school careers.

A major goal of the School of Medicine is to help students become safe physicians, i.e., by providing for them a carefully designed, six-year, combined baccalaureate-medical school program. This program is so constructed that students are with physicians from the beginning of their post-high school careers. Just as there is continuity through six years of experience with an emphasis on the role and the responsibility of the physician, so too there is, through six years, emphasis on the components and the values of a liberal education as well as on the importance of the basic and behavioral sciences.

The student body, the faculty, hospital affiliations and physical facilities are all growing rapidly. There are now 240 students in the six-year program. The full-time, part-time and volunteer faculty includes 635 clinicians, basic scientists and behavioral scientists. Many of the basic and behavioral scientists are faculty members in the College of Arts and Sciences, the School of Dentistry and the School of Pharmacy at UMKC and have joint appointments with this School.

One of the major goals of the School, quite literally, is to be open and regional. In keeping with this philosophy, affiliations have been developed with many hospitals. As this is being written, students from the School are in the following community hospitals: Baptist Memorial Hospital, Children's Mercy Hospital, Independence Sanitarium and Hospital, Kansas City General Hospital and Medical Center, Menorah Medical Center, Research Hospital and Medical Center, St. Joseph's Hospital, St. Luke's Hospital, St. Mary's Hospital, Trinity Lutheran Hospital and Western Missouri Mental Health Center in Kansas City and St. John's Hospital in Springfield.

As is the case with any new and developing Medical School, we have been visited on a yearly basis by Site Teams from the Liaison Committee on Medical Education. This Committee has reviewed the plans, resources, students, faculty and activities of the School very carefully. At the conclusion of the site visit in December of 1972, the School received full accreditation and became a full institutional member in the Association of American Medical Colleges.

On May 12 of 1972, the first group of students graduated from the School. This group consisted of one woman and eight men. Each entered the School in the fall of 1971 with advanced standing by virtue of substantial biomedical course work after graduation from college. All are now in their first year of house officer work. Seven are in hospitals in Kansas City.

In the few short years since the first students were admitted, there has been a steady increase in the number of students who are applying for admission to the six year program. These students apply during the course of their senior year in high school. There were 60 students who applied for admission initially. This number now stands at 415 for the class which will begin studies at the end of August of this year. The student applicants are a remarkably able group. The Council on Selection brings to the evaluation of each applicant the same careful and detailed study that is used by any medical school Admission Committee.

To turn to one selected portion of the Medical School program, the School has developed a one-month family practice preceptorship program in the summer between the student's second and third year in the six year program. The intent is to have each student spend a full month with a family practitioner to see at first hand the role, importance and satisfactions of providing family care. The intent also is to develop opportunities for as many students as possible to have their family practice preceptorship with physicians in smaller communi-

(Continued on page 251)

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CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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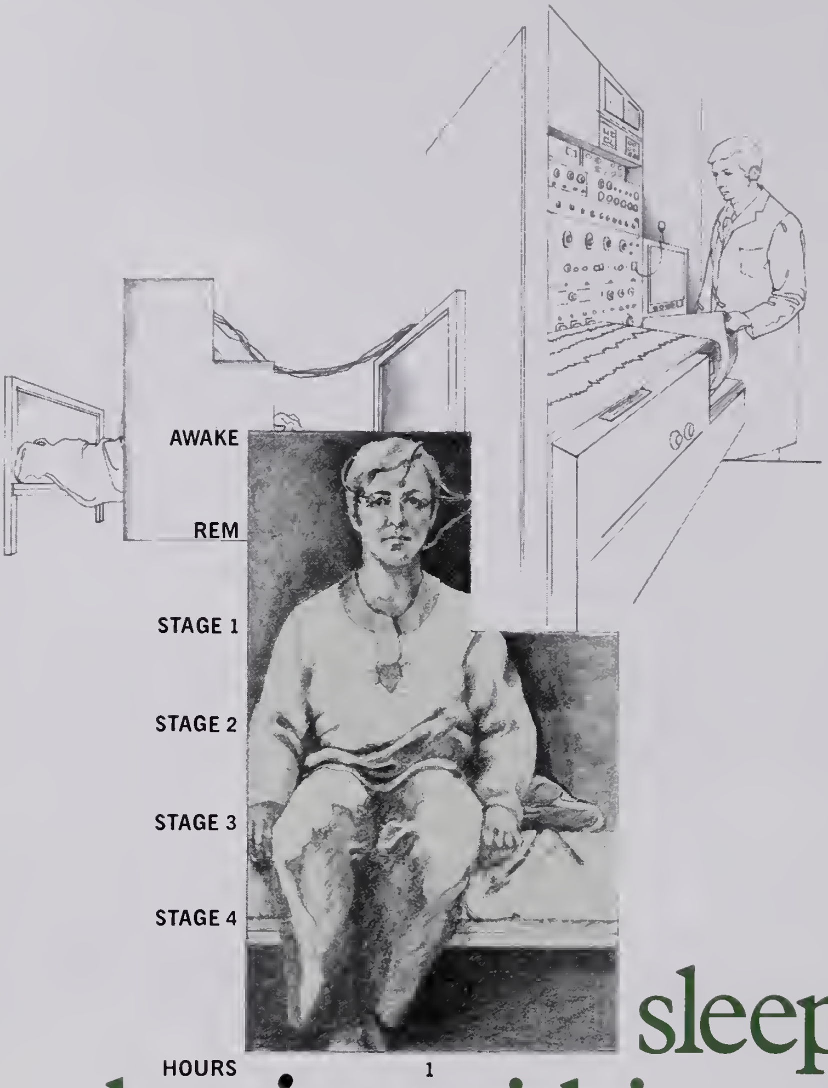

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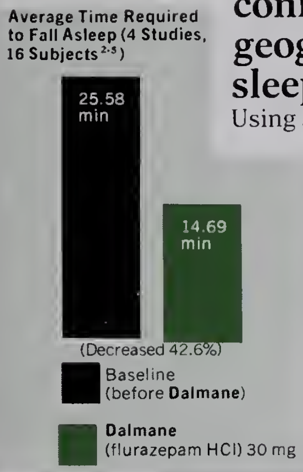

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Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

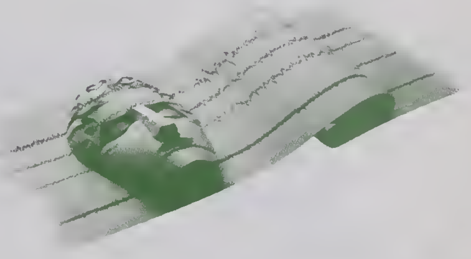
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®

(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

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3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant
Secretary for Health
Department of Health,
Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

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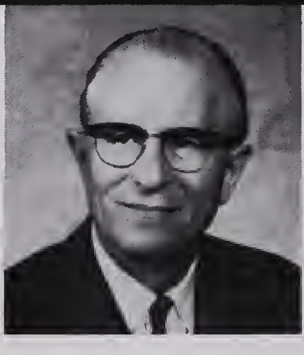
Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

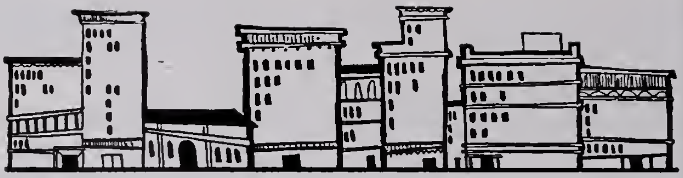
Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

From the Medical Schools



UNIVERSITY OF MISSOURI-COLUMBIA

Dr. Heyssel

Dr. Robert Morris Heyssel, executive vice-president and director of The Johns Hopkins Hospital in Baltimore and president of Columbia (Md.) Hospital and Clinics Foundation, has received the 18th annual Citation of Merit awarded to an outstanding alumnus of the University of Missouri-Columbia School of Medicine.

The award was presented to him during the annual session of the Missouri State Medical Association in Kansas City at the luncheon for Missouri medical alumni held at Crown Center on April 5.

Dr. Heyssel, who received his B.S. in Medicine degree from UMC in 1951, is the son of Mr. and Mrs. C. D. Heyssel of Columbia.

After completing his basic medical science education at Missouri's two-year medical school, Dr. Heyssel completed his clinical training and received his M.D. degree from St. Louis University in 1953.

Dr. Henry Pinkerton, professor and chairman emeritus of the St. Louis University School of Medicine *(right)*, accepts Gold Headed Cane Award from Dr. Kenneth M. Brinkhous, president of the American Association of Pathologists and Bacteriologists.

The second edition of "Textbook of Immunology" by Prof. *James T. Barrett* of the School of Medicine has recently been published by C. V. Mosby Co., St. Louis.

The first edition, issued in 1970, was reprinted to meet demands for the text which has been adopted by many leading universities in the United States. The newest edition has an additional chapter on tissue transplantation and tumor immunology, plus updated and added material in all other chapters. *Dr. Edward Adelstein* and *Dr. Donald Senhauser* of the UMC Department of Pathology provided some electron micrographs for the new edition.

Dr. Robert L. Carolla, assistant professor in the Department of Internal Medicine, has been awarded a Junior Faculty Clinical Fellowship by the American Cancer Society to further his potential as a future leader in the cancer field.

ST. LOUIS UNIVERSITY

Dr. Henry Pinkerton is the recent recipient of the 1974 Gold Headed Cane Award, the highest honor that fellow pathologists can bestow upon a colleague. The award was presented to the noted scientist at the Meeting of the AAPB in San Francisco on March 11. The Gold Headed Cane is one of U. S. medicine's oldest and most illustrious awards. The Cane is given to a physician who "represents the highest ideals in pathology and medicine."

The actual cane is a replica of one used from 1689 to 1825 by five British royal physicians. The original was carried with powerful aromatic preparations in its perforated golden head as a supposed protection against contagion. The official AAPB Cane, inscribed with the name of Dr. Pinkerton and others who have won it, is on display at the Armed Forces Institute of Pathology in Washington.

Dr. Pinkerton is noted for his research contributions to the understanding of the pathology of viral diseases, such as influenza, yellow fever and encephalitis, and rickettsial diseases, such as typhus, Rocky Mountain spotted fever and psittacosis (parrot fever). Lately, he has been working on cancer research with *Dr. Maurice Green*. As an active researcher, he holds the rank of active investigator at the School's Institute for Molecular Virology.

Dr. George E. Gantner, Jr., professor of pathology, has been elected a member of the Board of Directors of the National Association of Medical Examiners for a three-year period. He earned both the B.S. and M.D. degrees from St. Louis University. He is chief medical examiner for St. Louis County and director of laboratories for the St. Louis University Hospitals.

Dr. Raymond G. Slavin, director of the section of allergy and immunology, was a guest lecturer in Milwaukee on March 19. He delivered an address titled "The Burden of Air Pollution" before the Milwaukee Academy of Medicine. He also participated in Medical Grand Rounds at Medical College of Wisconsin. His lecture was titled "Diagnostic Tests in Clinical Allergy."

WASHINGTON UNIVERSITY

The American Academy of Orthopaedic Surgeons has awarded the Carl Berg Traveling Fellowship to *J. Andy Sullivan*, M.D., a member of the Washington University School of Medicine faculty.

This summer, the award will enable Dr. Sullivan, an orthopedic surgery resident, to observe treatment of children with diseases and deformities of the joints and spine in the United States and Canada.

Under the auspices of the Orthopaedic Research and Education Foundation, he will visit the Alfred I. Dupont Institute for Crippled Children, Wilmington, Del.; Boston Children's Hospital; Philadelphia Shriners' Hospital; and the Toronto Hospital for Sick Children.

The Mary Rankin and Ettie A. Jordan Charitable Foundation has given $30,000 to the Washington University Medical Service (Unit I) at the St. Louis City Hospital, Max G. Starkloff memorial.

Judge James M. Douglas, a trustee of the St. Louis-based foundation, announced that the funds will purchase a fluoroscope with image-intensifier for the hospital's 7-bed cardiovascular intensive care unit.

Dr. John R. Smith, Professor of Medicine and Chief of the hospital's Cardiovascular Division, said the new equipment will permit greater effectiveness in the management of patients in this vital life-saving area.

The fluoroscope will also be used in research. Dr. Mohammad Farooq Ghani, Instructor in Medicine, and Associate Director of the Division, is engaged in studies of rhythm disturbances of the heart in heart attack, and the causes of shock in heart attack which is so often fatal.

University of Missouri-Kansas City

(Continued from page 248)

ties in western Missouri. Dr. Walter J. Stelmach was instrumental in developing this program for the first students who were in such preceptorships in the summer of 1973. At that time, 36 students were in the program.

At this time, Dr. Stelmach and Dr. R. Stacy Long are planning the program for the summer of this year. Since the number of students increases each year during the activation phase of the School, there will be approximately 70 students in family practice preceptorships this summer. The School welcomes the interest and participation of so many family practitioners in this important, early introduction of all students to family practice and to a first hand experience with the health care needs in many portions of our state.

Letters to the Editor

(Continued from page 243)

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New Members

Richard Adair, M.D., 5140 Antioch Rd., Kansas City, has become a member of Clay County Medical Society. Dr. Adair is a native of San Diego, Calif., received his preliminary education at Harvard College and his M.D. degree at Harvard Medical School in 1968. He specializes in internal medicine.

John W. Beeks, M.D., P.O. Box 11009, Kansas City, has become a member of Clay County Medical Society. Dr. Beeks is a native of Kansas City, received his preliminary education at Baker University and his M.D. degree at the University of Kansas in 1965. He is in the general practice of medicine.

Daniel J. Brennan, M.D., 5941 Coronado, St. Louis, has become a member of St. Louis Medical Society. Dr. Brennan is a native of St. Louis, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1967. He specializes in plastic surgery.

Tapan K. Chaudhuri, M.D., 9406 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Chaudhuri is a native of Calcutta, India, received his preliminary education at Scottish Church College and his M.D. degree at Calcutta Medical College in 1963. He specializes in internal medicine.

Harry O. Cole, M.D., 5505 Delmar, St. Louis, has become a member of St. Louis Medical Society. Dr. Cole is a native of Missouri, received his preliminary education at Drury College and his M.D. degree at Washington University in 1965. He specializes in neurosurgery.

Robert L. Coscia, M.D., 1446 N. Robberson, Springfield, has become a member of Greene County Medical Society. Dr. Coscia is a native of Memphis, Tenn., received his preliminary education at Texas A&M University and his M.D. degree at the University of Tennessee in 1962. He specializes in general and peripheral vascular surgery.

Ernst P. Danielsson, M.D., 3324 E. Redbud La., Springfield, has become a member of Greene County Medical Society. Dr. Danielsson is a native of Reykjavik, Iceland, received his preliminary education at Reykjavik College and his M.D. degree at the University of Iceland in 1964. He specializes in plastic surgery.

Robert M. Feibel, M.D., 660 S. Euclid, St. Louis, has become a member of St. Louis County Medical Society. Dr. Feibel is a native of Ohio, received his preliminary education at Johns Hopkins University and his M.D. degree at Harvard Medical School in 1969. He specializes in ophthalmology.

James K. Fisher, M.D., 44th and Wornall, Kansas City, has become a member of Jackson County Medical Society. Dr. Fisher is a native of Independence, received his preliminary education at the University of Missouri-Kansas City and his M.D. degree at the University of Kansas in 1969. He specializes in radiology.

Roger W. Hofmeister, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Hofmeister is a native of Quincy, Ill., received his preliminary education at Western Illinois State University and his M.D. degree at the University of Illinois in 1960. He specializes in family medicine.

Robert C. Hoye, M.D., 301 W. Liberty, Farmington, has become a member of Mineral Area County Medical Society. Dr. Hoye is a native of Detroit, Mich., received his preliminary education at the University of Detroit and his M.D. degree at St. Louis University in 1956. He specializes in general surgery.

Thomas L. Huffman, M.D., 200 W. Chestnut, Butler, has become a member of West Central County Medical Society. Dr. Huffman is a native of Kansas City, received his preliminary education at the University of Missouri-Columbia and his M.D. degree at the University of Missouri in 1972. He is in the general practice of medicine.

Cathy C. Jarvis, M.D., 164 W. Clayton Rd., Ballwin, has become a member of St. Louis County Medical Society. Dr. Jarvis is a native of Indiana, received her preliminary education at the University of Missouri-Columbia and her M.D. degree at the University of Missouri in 1969. She specializes in internal medicine.

Robert E. Kipfer, M.D., 1550 E. Sunshine, Springfield, has become a member of Greene County Medical Society. Dr. Kipfer is a native of Wichita, Kan., received his preliminary education at the College of Emporia and his M.D. degree at the University of Kansas in 1966. He specializes in gastroenterology and internal medicine.

Sung Ae Lee, M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. Lee is a native of Pusan, Korea, received his preliminary education at Yonsei University and his M.D. degree at Yonsei University in 1963. He specializes in radiology radiation therapy.

Bruce A. McClelland, M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. McClelland is a native of Chicago, Ill., received his preliminary education at the University of Illinois and his M.D. degree at the University of Illinois in 1972. He specializes in dermatology.

Issa Moallempour, M.D., 3545 Ritz Center, St. Louis, has become a member of St. Louis Medical Society. Dr. Moallempour is a native of Iran, received his preliminary education at Farhang School in Iran and his M.D. degree at the University of Tehran in 1963. He specializes in general surgery.

Charles N. Mullican, M.D., 510 Francis, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Mullican is a native of Chicago, Ill., received his preliminary education at the University of Cincinnati and his M.D. degree at the University of Cincinnati in 1962. He specializes in internal medicine.

George B. Neukom, M.D., Farmington State Hospital, Farmington, has become a member of Mineral Area County Medical Society. Dr. Neukom is a native of Terre Haute, Ind., received his preliminary education at the University of California and his M.D. degree at Creighton University in 1939. He specializes in psychiatry.

Adamor R. Perez, M.D., 10844 Big Bend, St. Louis, has become a member of St. Louis Medical Society. Dr. Perez is a native of the Philippines, received his preliminary education at the University of the Philippines and his M.D. degree at the University of the Philippines in 1965. He specializes in surgery.

Gerald Pittman, M.D., 10845 Baur Blvd., St. Louis, has become a member of St. Louis Medical Society. Dr. Pittman is a native of Oklahoma, received his preliminary education at Central Methodist College and his M.D. degree at the University of Missouri in 1966. He specializes in pathology.

Dasari V. Ratnam, M.D., 2310 Linwood, Kansas City, has become a member of Jackson County Medical Society. Dr. Ratnam is a native of India, received his preliminary education at Hindu College and his M.D. degree at Guntar Medical College in 1965. He specializes in psychiatry.

Andrew J. Rhodes, M.D., 1734 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Rhodes is a native of Huntsville, Ala., received his preliminary education at Fisk University and his M.D. degree at Meharry Medical College in 1967. He specializes in neurological surgery.

Wallace A. Rogers, Jr., M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. Rogers is a native of Des Moines, Ia., received his preliminary education at Iowa State University and his M.D. degree at the University of Minnesota in 1965. He specializes in pathology.

Richard Rudman, M.D., 6420 Clayton Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Rudman is a native of New York, received his preliminary education at Tulane University and his M.D. degree at Louisiana University in 1966. He specializes in radiology.

T. James Sammon, M.D., 609 Cherry, Springfield, has become a member of Greene County Medical Society. Dr. Sammon is a native of San Francisco, Calif., received his preliminary education at the University of San Francisco and his M.D. degree at St. Louis University in 1968. He specializes in pediatrics.

Jack E. Shalley, M.D., 4240 Blue Ridge Blvd., Kansas City, has become a member of Jackson County Medical Society. Dr. Shalley is a native of Nevada, Ia., received his preliminary education at the University of Iowa and his M.D. degree at the University of Iowa in 1967. He specializes in psychiatry.

R. Wayne Shelton, M.D., 1211 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Shelton is a native of Bolivar, received his preliminary education at Southwest Missouri State College and his M.D. degree at the University of Missouri-Columbia in 1969. He specializes in ophthalmology.

Donald Sislen, M.D., 615 S. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Sislen is a native of Kansas, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1968. He specializes in internal medicine.

Don D. Sponenberg, M.D., 1211 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Sponenberg is a native of Wichita, Kan., received his preliminary education at Wichita State University and his M.D. degree at the University of Kansas in 1970. He specializes in pediatrics.

Jack L. Stuber, M.D., 24th and Cherry, Kansas City, has become a member of Jackson County Medical Society. Dr. Stuber is a native of St. Joseph, received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1966. He specializes in radiology.

Vannarth Sumathy, M.D., 825 Euclid, Kansas City, has become a member of Jackson County Medical Society. Dr. Sumathy is a native of India, received her preliminary education at Madras University and her M.D. degree at Madras Medical School in 1961. She specializes in obstetrics and gynecology.

Fataneh Tavassoli, M.D., 7311 Hoover, Apt. 301, St. Louis, has become a member of St. Louis Medical Society. Dr. Tavassoli is a native of Iran, received her preliminary education at Southwest Missouri State College and her M.D. degree at St. Louis University in 1972. She is a resident in pathology.

Joseph M. White, M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. White is a native of Dallas, Tex., received his preliminary education at Southern Methodist University and his M.D. degree at the University of Texas in 1947. He specializes in anesthesiology.

In Memoriam

William J. Rutledge, M.D., Campbell, a graduate of the University of Arkansas, 1911; member of Dunklin County Medical Society; age 90; died Feb. 24, 1974.

Joseph Lederman, M.D., 2400 N. Grand Blvd., St. Louis, a graduate of St. Louis University, 1937; member of St. Louis Medical Society; age 60; died Feb. 25, 1974.

Eugene M. Lucke, M.D., 4000 McMasters Ave., Hannibal, a graduate of Washington University, 1912; member of Marion Ralls Shelby County Medical Society; age 84; died Feb. 27, 1974.

Sandor D. Papp, M.D., Medical Arts Bldg., Joplin, a graduate of Rush Medical College, 1935; member of Jasper County Medical Society; age 65; died March 3, 1974.

Charles A. Brasher, M.D., Mount Vernon, a graduate of Washington University, 1936; member of Ozarks County Medical Society; age 65; died March 3, 1974.

Arthur D. Knabb, M.D., 1630 N. Jefferson, Springfield, a graduate of St. Louis University, 1913; member of Greene County Medical Society; age 85; died March 7, 1974.

Emmett J. Senn, M.D., Herculaneum, a graduate of Washington University, 1935; member of Jefferson County Medical Society; age 64; died March 7, 1974.

Richard Y. Kimura, M.D., 66551 Chippewa, St. Louis, a graduate of Tulane University, 1963; member of St. Louis County; age 41; died March 11, 1974.

Leonid Swidnicki, M.D., 1568 S. 500 W., Bountiful, Utah, a graduate of Ludwig-Maxmilian University, 1954; member of Marion-Ralls-Shelby County Medical Society; age 50; died March 12, 1974.

Elmer J. T. Anderson, M.D., Montgomery City, a graduate of the University of Louisville, 1934; member of Montgomery County Medical Society; age 65; died March 14, 1974.

Earl G. Padfield, Jr., M.D. 4320 Wornall Rd., Kansas City, a graduate of the University of Kansas, 1944; member of Jackson County Medical Society; age 54; died March 24, 1974.

B. Albert Lieberman, Jr., M.D., 4620 J. C. Nichols Parkway, Kansas City, a graduate of the University of Pennsylvania, 1931; member of Jackson County Medical Society; age 66; died March 29, 1974.

Melvin E. Staehle, M.D., 7325 Ravinia Dr., St. Louis, a graduate of Washington University, 1929; member of St. Louis County Medical Society; age 72; died April 1, 1974.

Donald M. Dowell, M.D., 913 Webster, Chillicothe, a graduate of Washington University, 1929; member of Grand River County Medical Society; age 70; died April 9, 1974.

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

The Medical Fund Society, acting through the medium of the St. Louis Medical College, was the fourth school in the United States to establish an optional course in 1879 and a three-year obligatory graded course in 1880, 12 years before any other school in this vicinity dared to take such a step. According to "Garrison's History of Medicine," The Harvard Medical School was the first in our country to adopt a three-year graded course (1871). The University of Pennsylvania and Syracuse Medical School took the same step in 1877, while the Ann Arbor Medical School and the St. Louis Medical College followed suit in 1880. However, neither in the publication of the Harvard Medical School dated 1782 to 1906 nor in "Garrison's History of Medicine" is it stated when the Harvard Medical School, the University of Pennsylvania Medical Department, the Syracuse Medical School or the Ann Arbor Medical School insisted that their three-year graded courses be obligatory.

The MSMA will convene for its 77th Annual Session at the Robidoux Hotel in St. Joseph on May 7-10. In 1920, the Association met in St. Joseph in a successful session and the enthusiastic and wholehearted work being done by the committees and the St. Joseph members give promise of another successful session. The Hotel Robidoux rates are single room with tub bath, $2.50 up and double, $3.50 up; single room with shower, $3 and double, $4.

TWENTY-FIVE YEARS AGO

William Anderson Bloom, M.D., Fayette, was elected President-Elect of the Missouri State Medical Association at the 91st Annual Session held in Kansas City on March 27-30. Wallace Smith, M.D., Springfield, was officially installed as President of the Association. Other newly-elected officers were Vice-Presidents, Drs. J. C. Creech of Troy, E. J. McIntire of Carthage and H. M. Henrickson of Poplar Bluff; Treasurer, C. E. Hyndman of St. Louis; Secretary, H. E. Petersen of St. Joseph; and Editor, R. O. Muether, M.D. of St. Louis.

Robert E. Schlueter, M.D., St. Louis, was presented the 1949 Award of Merit of the St. Louis Medical Society at a meeting in Dr. Schlueter's honor on April 5. Chauncey D. Leake, M.D., Galveston, spoke on "Books Make the Doctor" and R. Emmet Kane, M.D., St. Louis, spoke on "Surgeon-Scholar-Friend."

A Lloyd Stockwell, M.D., Kansas City, spoke on "Socialized Medicine" before the Independence Business and Professional Women's Club on February 28.

TEN YEARS AGO

Paul R. Whitener, M.D., St. Ann, was named President-Elect of the Missouri State Medical Association at the 106th Annual Session held on March 8-11 at the Hotel Chase in St. Louis. A general practitioner, Dr. Whitener will take office as President next year. Leonard T. Furlow, M.D., St. Louis, was installed as President at this session. Dr. Whitener, who was born in Fredericktown, graduated from Washington University School of Medicine in 1924. He served his internship and residency at the Methodist Hospital in Indianapolis, Ind. Vice-Presidents elected at this Annual Session include Ben M. Bull, M.D., Ironton; Ralph E. Duncan, M.D., Kansas City; and Edgar W. Davis, M.D., St. Louis County.

One hundred and eighty-eight members, guests and wives attended the Annual Installation of Officers and Dinner-Dance of the Greene County Medical Society on Feb. 15, 1964 at the Holiday Inn in Springfield. Dr. Harry D. Silsby, retiring President, officially installed Dr. Kenneth E. Knabb as the new President of the Society. Other officers who were installed were Drs. William H. Snead, President-Elect; Guy D. Callaway, Jr., Secretary; and Edwin M. Powell, Treasurer.

Martin E. Sheets, M.D., Chesterfield, was honored on his 88th birthday at a dinner at the Covenant Presbyterian Church in St. Louis. Dr. Sheets directed the St. Louis World Fair's hospital in 1904.

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INTERNIST NEEDED—Rural county-seat community of 1,800 with increasing population. Medical coverage of 10,000 people. New industry starting July, 1974 to employ 400 workers. Modern hospital facilities of 52 beds; two nursing homes of 90 beds; 50-bed Missouri Retardation Clinic. Excellent cooperation from medical staff of four. Financial arrangements available. Need EKG readings, consultations, critical care supervision and private practice. Located 100 miles from Kansas City, Des Moines and Omaha. Fifty miles from St. Joseph. Write to Box 394, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101 or call 816-726-3400 or 816-726-5221.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Missouri Medicine

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117th MSMA Annual Session
April 17-20, 1975, St. Louis

Both often

Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequer and/ or severity of grand mal seizures m require increased dosage of standard ar convulsant medication; abrupt withdrav may be associated with temporary increase in frequency and/ or severity of seizures. Advise against simultaneous ir gestion of alcohol and other CNS depres sants. Withdrawal symptoms (similar to those with barbiturates and alcohol) ha occurred following abrupt discontinuan (convulsions, tremor, abdominal and m cle cramps, vomiting and sweating). Ke addiction-prone individuals under caref

respond to one

According to her major
nptoms, she is a psychoneu-
ic patient with severe
xiety. But according to the
scription she gives of her
lings, part of the problem
y sound like depression.
is is because her problem,
hough primarily one of ex-
sive anxiety, is often accom-
nied by depressive symptom-
logy. Valium (diazepam)
provide relief for both—as
excessive anxiety is re-
ed, the depressive symp-
ns associated with it are also
en relieved.

There are other advan-
es in using Valium for the
nagement of psychoneu-
ic anxiety with secondary
ressive symptoms: the
chotherapeutic effect of
lium is pronounced and
id. This means that im-
vement is usually apparent
he patient within a few
s rather than in a week or
two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

veillance because of their predisposi-
to habituation and dependence. In
gnancy, lactation or women of child-
ring age, weigh potential benefit
inst possible hazard.

cautions: If combined with other psy-
tropics or anticonvulsants, consider
efully pharmacology of agents em-
ved; drugs such as phenothiazines,
cotics, barbiturates, MAO inhibitors
other antidepressants may potentiate
ction. Usual precautions indicated in
ents severely depressed, or with latent
ression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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another type for Tylenol
(acetaminophen)

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References: **1.** Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A. D., and Pearson, H. A.: J. Pediat. *78*:558-560 (March) 1971.

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MSMA NEWS ROUND-UP

JUNE, 1974

Important bills pass Legislature

The recently concluded second session of the 77th Missouri General Assembly has been characterized by many in the press as a "political session."

It is true there was some infighting, blame-placing and even name calling. Several major issues including campaign financing and the death penalty took a considerable amount of the legislator's time.

In the short session two years ago, 247 legislative proposals were approved. In the session just ended, only 140 bills were passed. Medicine was quite fortunate. Most of the bills supported by the MSMA made their way through the legislative tangle and will, hopefully, soon become law while all of the bills MSMA opposed failed to gain passage.

BILLS PASSED (MSMA Supported)

The "Sick Doctor" Bill (HB 1328) has been signed by the Governor and will become effective August 13, 1974. This law provides that the Board of Healing Arts can require a sick physician to meet certain criteria in able to practice. The bill is designed to protect the public and to salvage sick physicians.

Insurance for Newborn (HB 1487) was approved, but has not yet been signed by the Governor. This model bill provides that all individual and group health insurance policies would automatically afford coverage for newly born children of the insured from moment of birth. Law applies to all policies delivered more than 120 days after the effective date, which is August 13.

Physical Therapists Licensing Bill (SB 336) has been signed by the Governor. This law strengthens the present law by prohibiting a person not licensed as a physical therapist from representing himself as a physical therapist. Law does not prohibit schools, Y's, clubs, etc. from furnishing "therapy" to players, nor does it prohibit masseurs from engaging in their practice provided they do not represent themselves as physical therapists.

The Governor's bill on High-Risk Maternity and Pre-Natal Care was combined with a State Aid for Public Hospitals bill, sponsored by Democrat legislators, and passed. The Governor has not yet signed the bill and has expressed displeasure with some provisions.

Continued on back Insert page

Dr. Cross elected MSMA student loan foundation president

Albert D. Cross, M.D., of Trenton, has been elected President of the Missouri State Medical Foundation, the MSMA's medical student loan program.

Kenneth C. Hollweg, M.D., of Kansas City, was elected Vice President and Charles R. Doyle, M.D., of St. Louis, was elected Secretary-Treasurer. Robert H. Tanner, M.D., of Jefferson City, was elected to the Board of Trustees and joins Miles C. Whitener, M.D., of St. Louis County, Max S. Franklin, M.D., of St. Louis, and James C. Cope, M.D., of Columbia.

During the meeting, it was pointed out that since the Foundation was established in 1961, nearly $600,000 has been loaned to Missouri residents who have completed at least one semester of medical school.

The medical student loan program is supported by a $10 annual assessment on all active MSMA members plus contributions and bequests from individuals, medical societies and medical society auxiliaries. The Grand River Medical Society presented the Foundation with a $200 contribution at the meeting.

One of the main topics at the meeting concerned methods of publicizing to Missouri physicians and their wives that the Foundation could be aided directly through voluntary donations and in last wills and testaments.

A proposal to increase the early interest rates was delayed until the 1975 meeting. The current rates are 2 percent through two years after graduation from medical school followed by annual increases to 4, 6 and 8 percent.

MSMA Council stresses CME

The MSMA Council has requested the Ad Hoc Committee on Continuing Medical Education to begin approval of ongoing CME programs in the state and to set up a mechanism to approve new programs.

Meeting May 24-25 in Jefferson City, the Council also discussed and made recommendations on several government programs and referred various Resolutions passed by the 1974 House of Delegates to committees and commissions.

The importance of proceeding with a state-wide and state-approved CME plan was pointed out by several of the Councilors. The Ad Hoc Committee on CME, chaired by Dr. Paul Young of Columbia, will meet June 8 to discuss steps by which to implement a continued medical education program.

The Council also directed the Executive Committee to study and begin implementing the portions of the Planning Committee's proposals as adopted by the House. Special attention will be given to the formation of a MSMA-sponsored professional liability insurance plan. Other actions to be viewed will be establishing an Association Policy Manual, hiring additional staff as field secretaries and investigating additional group-purchasing or group-leasing arrangements for members.

Other actions by the Council included:

- Approval of the Missouri Thoracic Society for representation on the MSMA Commission on Interspecialty Medicine.
- Referral to the Committee on Constitution and Bylaws a proposal to investigate the manner and means to permit election of Vice Councilors to serve in the absence of District Councilors.
- Support for the concept that the option of assignment should be included in any new major health insurance plan.
- A decision to request that Gov. Bond veto Senate Bill 392, dealing with the use of patients or inmates of certain institutions in research and experimentation.
- Approval of a letter to be mailed to the University of Missouri Board of Curators requesting that the M.D. program be returned to top priority status in the forthcoming fiscal year budget. The program had been dropped to No. 2 priority.
- Recommendation to each County Medical Society to consider the possibility of billing Auxiliary dues jointly with society dues.
- Referral to the Commission on Medical Economics a complaint concerning disproportion of fees paid to private physician offices and organized clinics under Medicaid.
- Discussion of a Uniform Hospital Admission and Discharge System, to be studied by a committee of the Missouri Board of Health, and direction that the MSMA ask the Board of Health for a copy of the committee's recommendations and that the MSMA get adequate representation on the committee and any future committees that may be set up to study this situation.

The Council also received reports and took further action on the Resolutions passed by the House of Delegates. Following is a list of the Resolutions, the action already taken and Council recommendations for further action. (A synopsis of all the Resolutions passed by the House was published in the May issue of MISSOURI MEDICINE.)

Resolution 2 (Seat Belt Legislation) — Referred to Legislative Committee.

Resolution 3 (Hospital Medical Staff Autonomy) — Publish summary of Darling Decision in Journal. Councilors to inform constituents.

Resolution 5 (Parliamentary Procedure) — Referred to Committee on Constitution and Bylaws.

Resolution 8 (Discriminatory Fees) — Has been sent to State Insurance Commissioner.

Resolution 13 (Hospital Board, Medical Staff Relations) — See Resolution 3.

Resolution 14 (Third Party Involvement in Practice of Medicine) — Referred to Commission on Medical Economics.

Resolution 16 (MSMA Communications) — Referred to Executive Committee.

Resolution 17 (Use of Combination of Drugs) — Information sent to AMA and Federal Drug Administration.

Resolution 18 (National Health Insurance) — Information sent to AMA.

Resolution 19 (Pre-Admission Certification) — AMA commended.

Resolution 20 (Physician Involvement in CHP) — Inform each County Society. Request societies to return information to Commission on Medical Economics.

Resolution 21 (Wage-Price Controls) — Information sent to Missouri Congressional Delegation; AMA commended.

Resolution 22 (Malpractice Insurance) — Ad Hoc Committee appointed to begin project. Members are Drs. Irving Clark, Kansas City, chairman; Robert L. Willcoxen, Joplin; Jerome I. Simon, St. Louis; R. Allen Chandler, Kansas City; Howard J. McAlhany, Springfield.

Resolution 23 (Insurance Coverage — Mental Illness) — Referred to Legislative Committee.

Resolution 24 (Drunk Drivers) — Referred to Legislative Committee.

Resolution 28 (Teaching Human Physiology in Schools) — Information sent to Missouri Department of Education.

Resolution 29 (PSRO in Government Hospitals) — Information sent to Department of HEW, Social Security Administration and AMA.

Resolution 30 (Ratify Equal Rights Amendment) — Information sent to Missouri General Assembly.

Resolution 31 (Complete Maternity Insurance Coverage) — Referred to Legislative Committee.

Resolution 32 (Politics in V.A. Hospitals) — Information sent to Department of HEW and Social Security Administration.

Resolution 33 (Coordinate AMA-ERF Recipients) — Resolution submitted to AMA House of Delegates.

Resolution 35 (Support HB 1254) — Legislative Committee chairman supported bill before General Assembly committee.

Resolution 36 (Repeal of PSRO) — Information sent to President of United States, Missouri Congressional Delegation, Department of HEW and Missouri General Assembly.

Resolution 37 (Vaughn Citation) — Citation being prepared.

Resolution 38 (MSMA Constitutional Convention) — Referred to Planning Committee.

Resolution 40 (Unified AMA-MSMA Membership) Referred to Committee on Constitution and Bylaws. Information will be published fully so membership is knowledgeable on issue.

Resolution 41 (Oppose U.S. SB 2994, HB 12053) — Information sent to Missouri Congressional Delegation and AMA.

The Council also authorized the MSMA President to appoint committees to appear before and work with a Missouri General Assembly Interim Committee established to study possible licensure and regulations for physicians assistants, medical laboratories, acupuncturists and surgi-centers.

Major plans summarized

Congress focusing on national health insurance

With the opening of hearings on national health insurance proposals this spring, we offer, for your information and reference, the following summary of the major bills, prepared by American Medical News, the AMA's weekly newspaper.

Following is a brief summary of the major national health insurance proposals:

MEDICREDIT — AMA-sponsored bill provides comprehensive basic and catastrophic health insurance financed through tax credits or vouchers with full federal payments for the poor, and related to income otherwise. Estimated cost about $12 billion in "lost" revenues. Voluntary. Present private system of insurance utilized. Co-insurance and deductibles.

KENNEDY-MILLS — Social Security-financed and operated. Mandatory $31.5 billion would be collected from new Social Security payroll tax, plus $8.5 billion of added general revenues. Catastrophic coverage, co-insurance and deductibles, federal subsidization for poor. Private health insurance companies limited to role of fiscal intermediaries, supplemental coverage.

CHIP — Administration's plan, HEW-operated, revised and expanded version of original proposal, requires employers to provide comprehensive insurance for workers. Estimated new private costs — $31.5 billion; $6 billion general revenues. Federal underwriting of protection against catastrophic illness and costs to poor. Co-insurance and deductibles. Private health insurance companies remain dominant insurors.

AMERIPLAN — AHA-sponsored bill provides for establishment of new program of health care delivery through locally organized health care corporations. Establishes program of health insurance coverage, including catastrophic, with employers paying 75% of premiums. HEW would provide coverage for aged and indigent. Cost $18.1 billion new revenues. Run by a special Dept. of Health.

HEALTH SECURITY ACT — Labor bill provides for comprehensive health benefits for all financed through an employer-employee payroll tax and from general revenue. Cost, $80 billion or more. General revenue tax — $8.5 billion. Special board sets policy, HEW operates.

HEALTH INSURORS — System of national health insurance implemented through existing health insurance systems. Income tax credits for cost of benefits would be phased into private insurance over a 10-year period, catastrophic included. Insurance pools used to provide benefits to poor, near poor, and previously uninsurable. Cost, $8.1 billion added tax revenues.

LONG-RIBICOFF — Social Security-financed catastrophic coverage, assistance to low income people, stricter regulation of private health insurance. Cost, about $6 billion.

U.S. CHAMBER OF COMMERCE — Similar to but less broad than CHIP, requires employers to make health insurance available. Supplants Medicaid with totally-federal program. Insurance pool for self-employed, smaller businesses. Catastrophic, cost, $4 billion.

Physicians numbers rise

There were 9,845 more physicians in the United States at the end of 1973 than in the previous year, according to the American Medical Association's Center for Health Services Research and Development.

The final figure in the AMA master file of physicians at the end of the year was 366,379, compared with 356,534 at the end of 1972.

The number of physicians providing patient care rose from 292,210 in 1972 to 295,257 last year. Those listing their major activity as medical teaching rose from 5,636 in 1972 to 6,183 last year; the number in research dropped from 9,290 to 8,332.

The number of general practitioners decreased from 55,348 in 1972 to 53,946 last year. Physicians in medical specialties rose to 86,924 last year from 84,153 a year earlier; those in surgical specialties rose to 91,549 from 91,058.

Management Workshop held

Eighteen participants, mostly senior residents, took part in a management workshop for new physicians on May 6-7, at the St. Louis Medical Society Headquarters. The workshop was sponsored jointly by the MSMA and the AMA.

MSMA honors students

The Missouri State Medical Association's Honors Graduate Award and $100 U.S. Savings Bonds have been presented to the top graduating senior at three Missouri medical schools.

Those receiving the award and bond were Mrs. Margaret Woolf, Washington University School of Medicine; Kevin M. Ehrhart, St. Louis University School of Medicine; and Orlyn Lockard, University of Missouri-Columbia School of Medicine. The University of Missouri-Kansas City Medical School will participate in the program in future years.

Cure for 'shortages'

Two Philadelphia doctors have responded to the current "shortages" of various services and products in a unique method, according to the St. Louis Globe-Democrat.

The doctors posted this notice in their office: "Patients with even ages will be seen on even days and patients with odd ages will be seen on odd days."

"However," the notice continues, "patients who are completely odd, regardless of age, will be seen either day."

Acupuncture, chiropractic measures fail

Continued from Page 1

The bill provides state aid to public hospitals (and non-profit hospitals under contract with cities and counties) amounting to the lesser of 10 percent of the local hospital tax effort of the municipality or the total proposed expenditures for the improvement of patient care. Also, the bill provides for a program of care for women who have a high risk of developing conditions leading to premature births or who might produce mentally retarded children. Program includes diagnostic and treatment centers for such women.

BILLS PASSED (Of Interest)

An Abortion Bill (HB 1211) was passed but has not yet been signed. The bill provides that no abortion could be performed in the first 12 weeks except by a licensed physician and with the consent of the woman, her spouse or a parent if she is under 18 and unmarried. Abortions after the first 12 weeks must meet the same criteria and be performed in a hospital.

In later pregnancies, prohibits any abortion not necessary to preserve the life or health of the mother unless the attending physician certifies with reasonable medical certainty that the fetus is not viable. Prohibits saline amniocentesis method after first 12 weeks. Requires reports on all abortions be filed with Division of Health.

"Patients Rights" Bill (SB 392) prohibits the use of or participation of inmates or patients of state correctional, medical and other institutions in clinical research projects without the informed consent of the patients or inmates or certain relatives or guardians. Depending on the nature of the research, the approval of the Division of Health or Division of Mental Health might also be required. Bill was amended in closing days of Session and the MSMA has called for the Governor to veto this measure.

BILLS NOT PASSED (MSMA-Opposed)

The several bills to repeal the 1973 Ambulance Law were not adopted. Beginning as a straight repeal bill, the legislation was changed to a state aid for ambulance districts measure. The Division of Health released its proposed ambulance regulations in April. Most legislators felt that the regulations as promulgated were quite reasonable and dropped their support of the repealer bills.

The Acupuncture Bill (HB 972) died in the Study Sub-Committee to which it was referred. The bill was too vague and appeared to open the practice of acupuncture to nearly anyone. Sentiment for "some type of regulations" was expressed by several committee members and acupuncture may again be an issue in the next General Assembly.

A bill which would have greatly expanded Crippled Children Services without providing necessary funds, failed to gain a hearing on the floor. This has become an annual bill.

Another annual measure, Removing the words "By Hand" from the chiropractic practice act, was not heard by the House Committee and the Senate Committee did not take action on its version.

Also, a Physical Therapist bill which would have opened the practice of P.T. to chiropractors, was not heard.

BILLS NOT PASSED (Of Interest)

The Delegation Amendment (SB 341) again ran into strong opposition and died on the Senate calendar.

A bill designed to provide Insurance for Psychiatric Care (SB 520) was poorly written and got off to a late start. The sponsor did not request a hearing.

Water Fluoridation (SB 527) was again heard, but gained little favor. Lawmakers seem to believe this type of project could be accomplished by the Division of Health.

A mandatory Seat Belt Usage bill (HB 940) was introduced, but not heard by Committee. The bill would have required drivers and passengers to wear seat belts.

A bill which would have required physicians to include the Generic Name of Drugs as well as the brand name on all prescriptions drew much heated testimony and its sponsor recommended further study.

Two bills dealing with the Treatment Of and Insurance For Alcoholism (HBs 1263 and 1264) received much favorable comment, but failed to progress.

A bill to Regulate and License Clinical Laboratories (SB 561) drew opposition from some private physicians and many chiropractors as being too limiting and was not acted upon.

PRELIMINARY OUTLOOK FOR 1975

An Interim Committee of the Missouri House and Senate has been established to consider, investigate and study the areas of physician assistants, medical laboratories, acupuncturists, surgi-centers and other related matters in respect to the possible need for licensure and regulation legislation. After taking testimony and gathering data, the Committee is to report its recommendations to the next General Assembly.

Legislative matters dictated by the House of Delegates for 1975 include:

*Support for Seat Belt Usage
*Support for Insurance for Mental Illness
*Support for Complete Maternity Coverage Insurance

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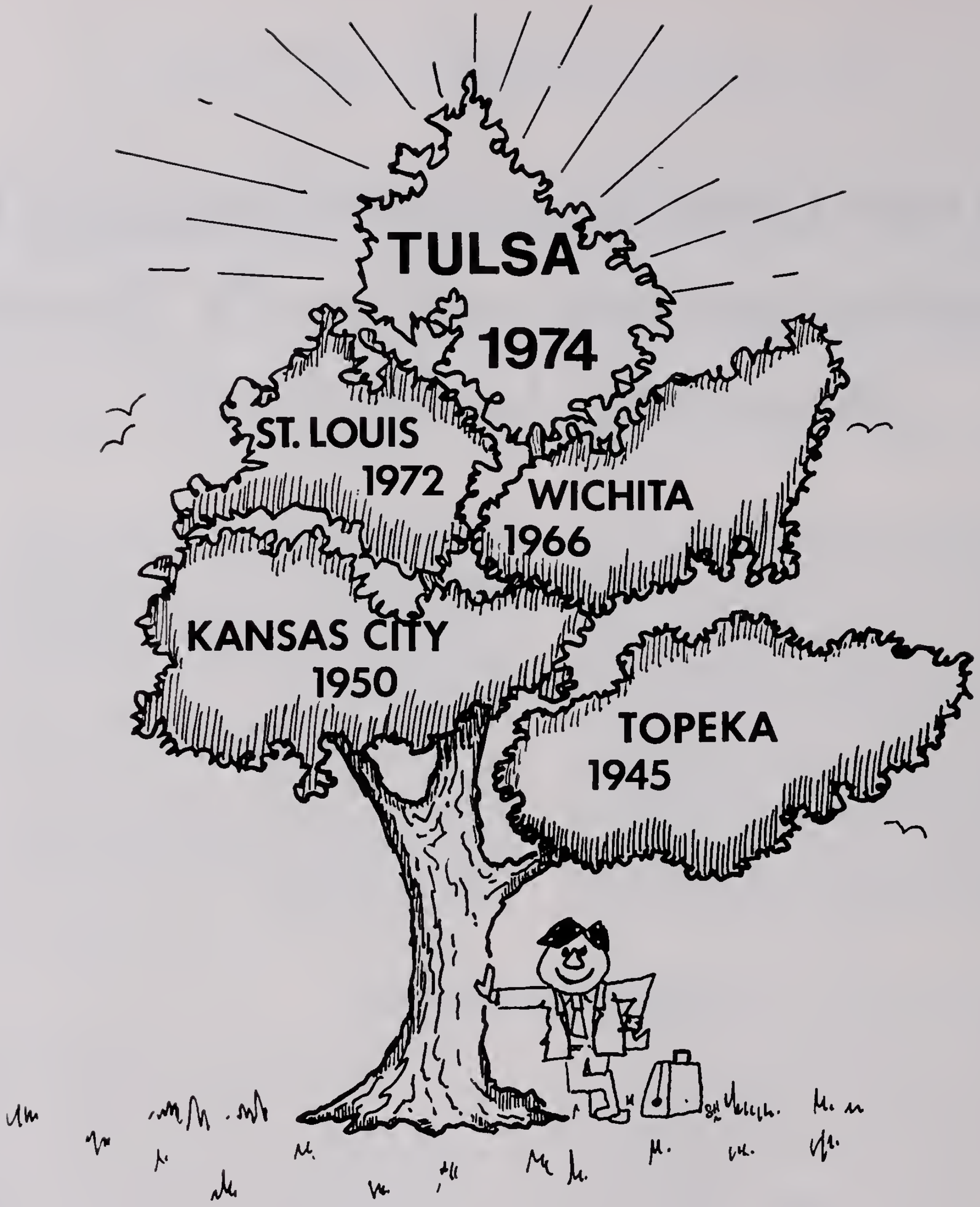

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YOUR INDEPENDENT SURGICAL SUPPLY DEALER

in Brief

A summary of AMA, medical & health news

American Medical Association/535 North Dearborn Street/Chicago, Illinois 60610/Phone (312) 527-1500/TWX 910-221-0300

AMA's contract for Project USA has been renewed until June 30, 1975. The project places physicians to serve as short-term replacements for National Health Service Corps physicians in areas of critical medical personnel shortages. Under the new contract, the AMA also will recruit physicians for long-term assignments in the NHSC. Physicians receiving long-term assignments will be government employees, either members of the Commissioned Corps of the Public Health Service or Civil Service. Project USA physicians will be reimbursed by the AMA.

Three specialty societies have released "Mini-CPT" editions. The booklets are published cooperatively by the AMA and the specialty societies, with the societies paying for printing and distributing their editions to their memberships without charge. Each edition is taken from a specific section of the third edition of AMA's *Current Procedural Terminology.* So far, the American Society of Internal Medicine has published *Procedural Terminology for Internists;* the American Academy of Pediatrics, *Procedural Terminology for Pediatricians;* and the American Academy of Neurology, *Procedural Terminology for Neurologists.* The American Association of Ophthalmology and other societies are expected to do so soon. The AMA carries no inventory of these items and individual specialty societies should be contacted for copies.

Physicians registering and participating in the American Society of Clinical Pathologists' postgraduate courses at the AMA's Annual Convention in Chicago in June will not have to pay AMA registration fees. ASCAP is offering seven pathology courses for non-pathologists during the mornings of June 22-26 at the ASCAP Continuing Education Center in Chicago. Shuttle bus service will be provided to and from the center by the AMA.

Loans totalling $4,146,523 were granted by the AMA-ERF Loan Guarantee Program in 1973. The 3,097 loans granted averaged $1,338 each. Since the program began in 1962, 51,797 loans for $59,481,298 have been granted to medical students, interns and residents.

U. S. Vice-President Gerald R. Ford will address the AMA House of Delegates on June 25 at the Annual Convention in Chicago.

About 200 physicians were placed last year through the AMA's Physicians' Placement Service. The PPS will have an exhibit at the AMA's Annual Convention in Chicago in June, where more than 2,000 physician resumes will be available to those seeking partners or associates. The placement service is free and those interested in having their resumes circulated at the exhibit are urged to write early for registration forms. Contact Physicians' Placement Service, AMA Headquarters.

Human health, as it relates to energy and the environment, is the subject of a new book published by the Publishing Sciences Group, Inc., in cooperation with the AMA Council on Environmental, Occupational, and Public Health. *Energy, the Environment, and Human Health* is available for $18.75 from Publishing Sciences Group, Inc., 411 Massachusetts Ave., Acton, Mass. 01720.

The first PSRO contract was granted to the Pennsylvania Medical Care Foundation, organized in 1971 by the Pennsylvania Medical Society. The 12-month contract provides about $250,000 for the development and operation of a statewide support center.

A California law prohibiting the licensing of osteopaths was declared unconstitutional by the state Supreme Court. The law was the outgrowth of a public referendum in 1962. At that time, osteopaths in California, the only state with such a law, were given the option of remaining D.O.s or accepting M.D. degrees. All but about 400 of the state's 2,250 D.O.s became M.D.s.

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JAMES F. McCOOL, M.D., *St. Louis*

Follicular Carcinoma of the Thyroid With Lymph Node Metastasis

Case Report

Thyroid carcinoma is relatively rare as a cause of death.[1] Follicular carcinoma of the thyroid is a differentiated adenocarcinoma with a strong tendency for blood vessel invasion. Local spread to the lymph nodes is said to occur in less than 3% of patients.[2] The following case report is unusual in that it represents a follicular carcinoma with the less common lymph node extension. The choice of combined surgical and ^{131}I therapy are discussed.

Case Report

A 76-year-old white man was given a routine periodic physical examination on May 6, 1971. He complained of a painful right thigh following an incidence of heavy lifting. There were no other complaints.

This man was actively engaged in his occupation as a commercial artist. Pertinent past history includes an episode of a transient right hemiparesis with no residue in 1965. In 1969, he spontaneously passed a left ureteral calculus. He also had complained of mild calf claudication when walking long distances.

The physical examination revealed a lean, well-developed white man who appeared to be younger than his stated age. His height was five feet and one-half inch. His weight was 141 pounds. A blood pressure reading was 140/70. His pulse rate was 63 beats per minute and regular. Pertinent physical findings showed a moderate AV nicking on the funduscopic examination, the absence of palpable pulses beyond the right femoral and the left popliteal arteries. The deep tendon reflexes were 4+ in the right arm and leg and 3+ in the left arm and leg. Otherwise, the neurological examination was negative.

A finding not noted previously was the presence of a hard, 2 cm nodule in the area of the right lobe of the thyroid. Laboratory studies disclosed the following values:

Urinalysis revealed a specific gravity of 1.022 with a pH of 5.0; microscopic was negative. The complete blood count was 9,000/cu mm; hemoglobin level, 16.2 gm/100 ml; hematocrit value, 49% with 31% lymphocytes, 5% monocytes, 4% eosinophils and 1% basophils. The SMA profile revealed calcium, 10 mg/100 ml; inorganic phosphorus, 3.7 mg/100 ml; glucose, 99 mg/100 ml; blood urea nitrogen, 21 mg/100 ml; uric acid, 5.9 mg/100 ml; cholesterol, 178 mg/100 ml; total proteins, 7.5 gm/100 ml; albumin, 4.3 gm/100 ml; globulin, 3.2 gm/100 ml; A/G ration, 1-3; total bilirubin, 0.6 mg/100 ml; alkaline phosphatase, 137 units/ml; LDH, 179 units/100 ml; serum glutamic oxaloacetic transaminase (SGOT), 16 units/100 ml; protein bound iodine, 6.2 μg/100 ml.

A chest x-ray was essentially negative. An ^{131}I uptake and scan of the thyroid was done. The uptake was 15.4%, and there was a diffuse distribution throughout the gland, except for a hypofunctioning nodule near the midline.

The author presents an unusual case report of a follicular carcinoma with the less common lymph node extension and discusses the choice of combined surgical and ^{131}I therapy. In this patient's age group, this combination has resulted in a significantly lower death rate than in those treated with surgery alone. Dr. McCool is in the private practice of internal medicine and Senior Instructor in Clinical Medicine, St. Louis University School of Medicine.

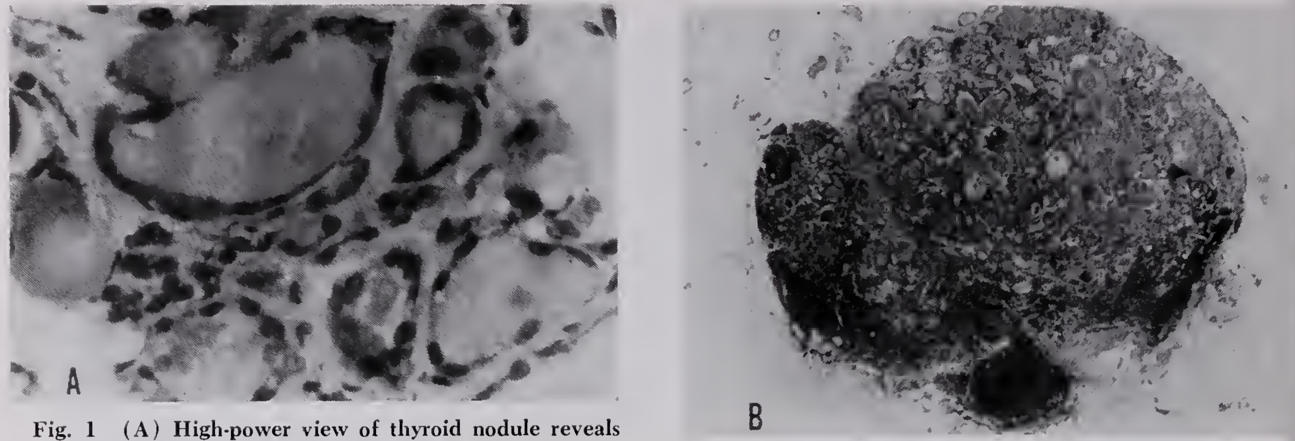

Fig. 1 (A) High-power view of thyroid nodule reveals a well differentiated follicular adenocarcinoma. (B) Low-power view of a lymph node shows involvement with the metastatic follicular adenocarcinoma.

The patient was seen in surgical consultation and was hospitalized. He underwent surgery on June 2, 1971. The pathologist interpreted the frozen section of the nodule as probably benign. The surgeon then chose to do a right lobectomy with removal of right cervical nodes which he considered to be grossly suspicious. The patient tolerated the surgical procedure without difficulty.

A final pathology report indicated the presence of follicular adenocarcinoma with lymph node extension (Fig. 1). There was no evidence of blood vessel invasion. On the third postoperative day, the patient insisted upon being discharged and refused to consider further surgery.

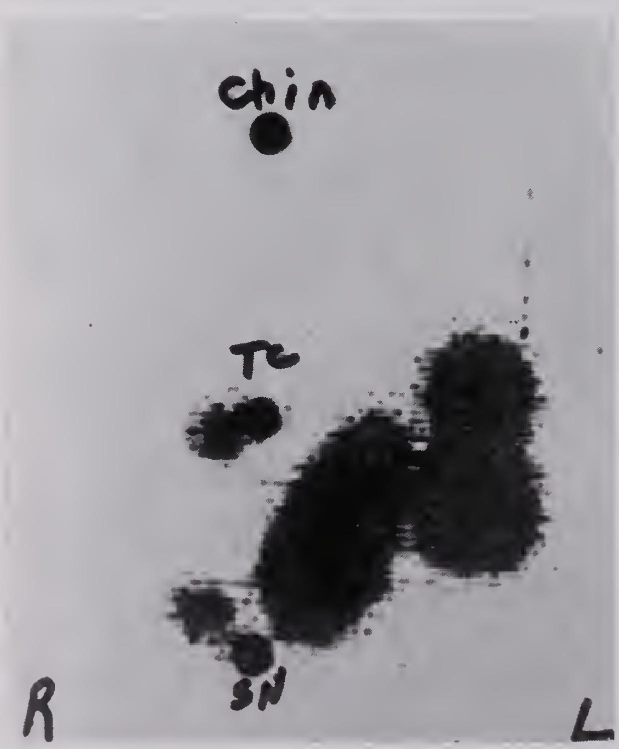

Fig. 2 Residual left lobe with functioning tissue lateral to it in two areas. Also, two small areas near the thyroid cartilage (TC) and sternal notch (SN) represent residual thyroid tissue surrounding parathyroid gland.

After leaving the hospital, he did not return to the office as scheduled and was not seen again for three months. When next seen, he received an intramuscular injection of 10 units of thyroid stimulating hormone (TSH) for three successive days, and a ^{131}I scan for evidence of metastasis was then performed (Fig. 2).

The use of ^{131}I therapy was discussed with the patient, but he then was not seen again for six months. When he finally returned and agreed to further therapy in March, 1972, he received TSH-10 units intramuscularly for three days. A repeat scan was performed (Fig. 3). The findings were essentially the same as on the previous scan.

He then received 150 millicuries of ^{131}I. Within one week, he developed tenderness and swelling of his pharynx. Three weeks after ^{131}I therapy, he received

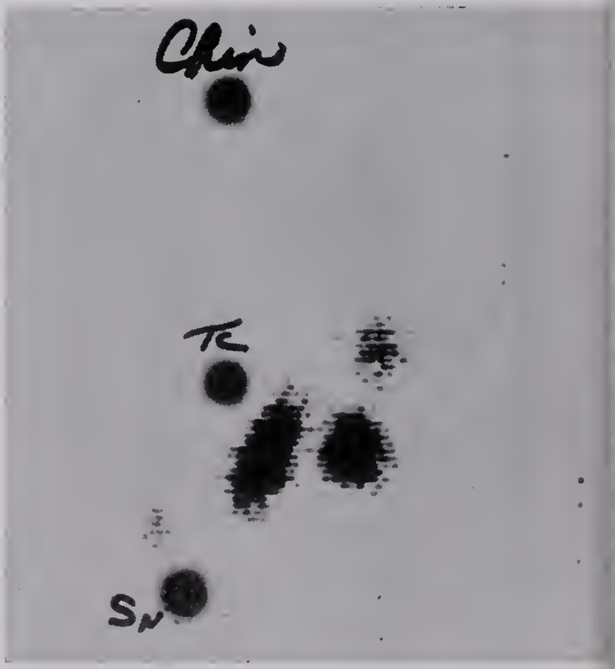

Fig. 3 Note the nearly identical findings to Fig. 2. The activity lateral to the left lobe is presumed to be metastatic disease.

0.3 mg of sodium levothyroxine (synthroid) daily. Six months later (Sept. 30, 1972), after administration of synthroid had been discontinued for one month, he was again scanned with ^{131}I after preparation with 40 mg of furosemide daily for three days and a single dose of TSH-10 units administered intramuscularly. (Further TSH was not administered because of a severe local reaction to the injection.) The scan revealed no evidence of any functioning tissue in the neck or mediastinum. He presently is receiving 0.2 mg of synthroid daily and remains clinically well.

DISCUSSION

This patient presented with a hard thyroid nodule which was asymptomatic. On initial scan, it appeared as a single cold nodule which raised the suspicion of malignancy.[3] At the time of surgery, the initial pathological opinion was against the nodule being a malignant tumor. The well-differentiated histologic pattern resembled normal thyroid tissue. Apparently, there still exists a problem in the interpretation of well-differentiated tumors.[4] The surgical removal of lymph nodes and the subsequent pathological findings of follicular adenocarcinoma within these nodes makes this case fit into the less common category of follicular adenocarcinoma with lymph node metastasis. The more common tendency of these tumors to invade blood vessels was not demonstrated in this case.

The use of total thyroidectomy might have been more beneficial as the initial therapy and is recommended by some outhors.[5-7] On the other hand, this histologic type of thyroid carcinoma does not tend to be multicentric and, in this sense, a complete thyroidectomy would not be required.[2] The removal of additional thyroid tissue before the use of ^{131}I therapy was considered in this case, but the patient refused further surgery. In addition, he was uncooperative for some time after discharge from the hospital.

It was not until six months after surgery that the patient returned for ^{131}I therapy. A postoperative scan revealed activity lateral to the remaining thyroid lobe, presumably metastatic involvement of the lymph nodes in this area. It was felt that sodium iodide ^{131}I therapy could be of benefit in this individual. The fact that this is a well-differentiated follicular carcinoma composed primarily of small follicles with colloid production should correspond with a good capacity to concentrate ^{131}I.[6] In this patient's age group, a combination of ^{131}I therapy with surgery has resulted in a significantly lower death rate than in those treated with surgery alone.[5]

A recent report has indicated that systematic ^{131}I therapy was not effective for control of thyroid cancer metastatic to cervical lymph nodes.[9] However, in this series, prior thyroidectomy was not done in some cases. This presumably would reduce the ability of the metastatic lesions to actively accumulate ^{131}I. In addition, no attempts were made to enhance the metastatic lesions uptake of ^{131}I either by the use of TSH or diuretics.[10] In one series, 36 patients with functional metastases from thyroid cancer were treated with ^{131}I; four patients had spontaneously functional metastasis, but 32 patients required induction of function.[6] In the present case, both TSH and a diuretic were used to enhance the uptake of ^{131}I. This patient eventually developed a severe local reaction to TSH, which is one of the problems reported with the use of this agent.[6] ^{131}I therapy is not without complications, as radiation pneumonitis and pulmonary fibrosis have been reported following this type of therapy and aplastic anemia is a potential complication.[11] On the other hand, pulmonary deaths from ^{131}I therapy represent a late complication occurring ten or more years following therapy and would not be a significant consideration in the older patient.

A large initial treatment dose of ^{131}I was chosen in this case because it was felt that the therapeutic effect of the ^{131}I would be reduced by the presence of the normally functioning left lobe.

The use of thyroid hormone may be effective in suppression of papillary carcinoma of the thyroid, but is generally not considered effective in follicular carcinoma.[2] The use of the hormone in this individual was thought to be indicated due to the fact that this is a well-differentiated tumor with the ability to concentrate radioactive iodine in its metastatic lesions. In addition, with the ablation of active thyroid tissue by ^{131}I therapy, some thyroid replacement therapy is needed to maintain a euthyroid state.

The above case has been a presentation of a follicular adenocarcinoma found on routine examination in an elderly individual. The tumor is unusual in its affinity for lymph node metastasis and lack of evidence of vascular invasion. His treatment consisted of surgery with lobectomy and removal of some metastatically involved nodes; although a more complete thyroidectomy would probably have been preferable, as discussed. A postoperative scan revealed evidence of local lymph node metastasis. The use of radioactive iodine was described as treatment for metastasis after surgery. The patient is to be followed at intervals with repeat scans for evidence of recurrence or activation of his disease.

(Continued on page 275)

Special X-ray Exhibit

SIDNEY RUBIN, M.D., RODGER LAMBIE, M.D., EDWIN HERMAN, M.D., NANCY WALDMAN, M.D. *and* **JOHN LEONIDAS, M.D.,** ***Kansas City***

Radiologic Problem Case

Two cases have been seen recently which required radiographic evaluation of renal status following abdominal trauma. With the increasing incidence of trauma, the approach to evaluation of the patient is most important. The most commonly injured organ in abdominal trauma is the kidney. Our two cases illustrate several important points in the approach to patients with a history of blunt abdominal trauma.

Case History: *(Case #1)* A 12-year-old boy was transferred to Menorah Medical Center several hours after an automobile accident in which he had injured his abdomen, head and right elbow. At the time of admission, he complained of pain in his right lower quadrant. There was grossly bloody urine in his catheter. Past family and medical history was noncontributory.

Physical Examination: The patient's blood pressure was 110/70; pulse rate, 76 and regular; and respiration rate, 18 per minute. The abdomen was soft with normal bowel sounds demonstrated. There was tenderness in the right lower quadrant with an associated localized contusion over the pubic symphysis.

Laboratory Examination: The complete blood cell count (CBC) revealed a hemoglobin level of 12.6 gm/100 ml; hematocrit value 38%; and white blood cells (WBC) 28,000. Urine analysis was grossly bloody with pH 5.0, specific gravity of 1.018 and proteinura of 3+. Microscopic observation revealed the urine to be loaded with red blood cells (RBC) and occasional WBC.

Radiographic Examination: X-ray examination revealed a fracture of the right superior pubic ramus. A cystogram was performed which demonstrated a normal bladder without evidence of extravasation of contrast media. An IVP revealed a nonfunctioning left kidney and a normal right kidney and ureter (Fig. 1). The renal scan showed no blood flow to the left kidney. An abdominal aortogram revealed no evidence of a left renal artery implying congenital absence of a left kidney (Fig. 2).

Hospital Course: The patient was treated for his various fracture deformities. During the hospital stay, the urine slowly returned to normal, becoming free of RBCs within ten days. No further sequela to the trauma has been demonstrated in this patient.

Case History: *(Case #2)* A 5-year-old boy presented with left upper quadrant pain and anorexia of two days duration. Two days prior to admission, the child had fallen on a concrete sidewalk while running. Since that time, he had developed mild abdominal distension and left upper quadrant pain. There was no history of nausea, vomiting or hematuria. Past medical and family history were noncontributory.

Physical Examination: The vital signs were obtained and revealed a temperature of 99.3 F; pulse rate, 120 beats per minute; respirations, 24 per minute; and blood pressure, 120/60. At the time of admission, there were abrasions noted over the left lower chest wall. The abdomen was slightly distended with mild rigidity. There was localized tenderness in the left upper quadrant, but no rebound phenomenon was demonstrated. The bowel sounds were decreased. No palpable masses were present.

Laboratory Studies: Laboratory studies show a hemoglobin level of 7.5 gm/100 ml; hematocrit value, 28%; and WBC, 11,000. The urinalysis obtained revealed a pH of 5.0 with specific gravity of 1.034 and proteinuria of +1. No cells were noted on the microscopic examination.

Radiographic Examination: Radiographic examination revealed a negative chest x-ray. The plain abdominal film demonstrated haziness in the pelvic region above the bladder and thickening of the preperitoneal fat line.

Hospital Course: A peritoneal tap demonstrated

The authors of this series of articles presenting unusual radiologic problem cases are from the Department of Radiology, Menorah Medical Center. Dr. Lambie is Chairman of the Department.

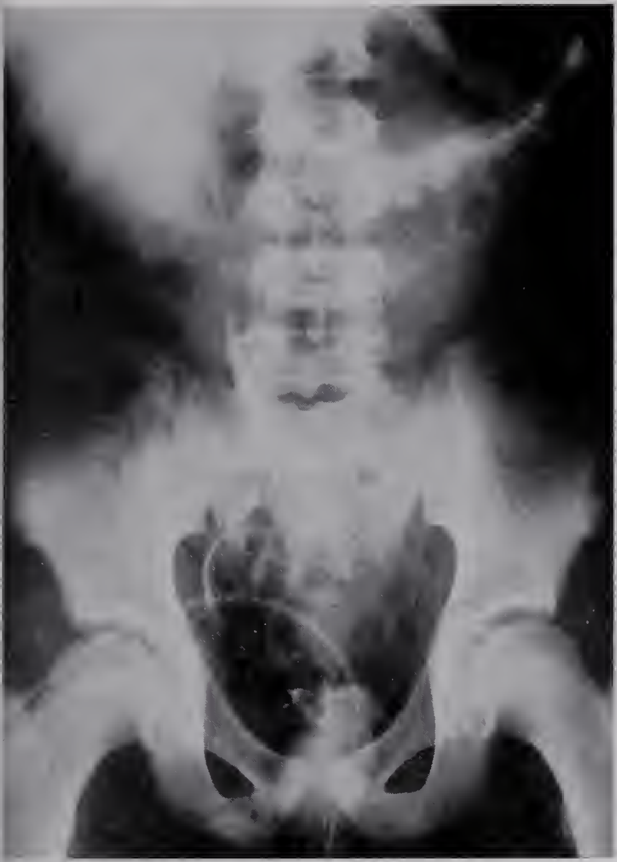

Fig. 1 Case #1. IVP with nonfunction of the left kidney. Note pubic fracture on right.

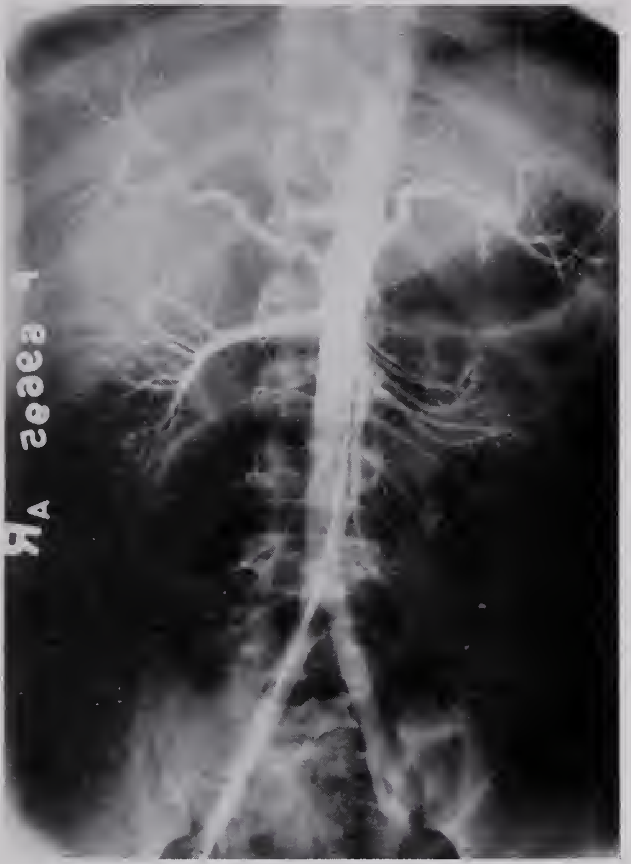

Fig. 2 Case #1. Aortogram with no evidence of left renal artery implying congenital absence.

pale fluid with 500,000 RBC's per cubic mm. An exploratory laparotomy and splenectomy were performed on the day of admission. A 1.5 cm tear within the splenic hilum was demonstrated with a well-formed thrombus about it. The kidney was palpated and thought to be intact. Postoperative urine culture grew hemolytic staphylococcus coagulus positive organism. An IVP was then performed and revealed no function of the left kidney with a normal right kidney, ureter and bladder (Fig. 3). Retrograde examination demonstrated a normal left pyelogram (Fig. 4). Fourteen days after admission, an arteriogram was performed, and demonstrated a complete occlusion of the left renal artery (Fig. 5). No evidence of hypertension was noted. The urine analysis, blood urea nitrogen (BUN) and creatinine were all within normal limits. The patient was discharged and continues to be followed in the surgical clinic.

DISCUSSION

After initial stabilization of vital signs, evaluation of the patient presenting with gross or microscopic hematuria includes several important modalities. The most common clinical indication of damage to the kidney following trauma is the presence of hematuria. However, approximately 10% to 25% of patients with renal injury do not have hematuria.[1] Clinical examination may reveal guarding and tenderness, which are findings not specific for renal trauma, and may reflect the composite response of several organ systems. Laboratory tests revealing a drop in the hematocrit do not localize the site of blood loss.

Radiologic examination usually begins with a plain film of the abdomen. Approximately 75% of patients with renal trauma will have negative plain abdomen films due to the fact that most renal injuries are minor.[1] This study may show loss of definition of the psoas shadow, scoliosis of the spine with concavity toward the side of injury, irregularity of the renal mass or elevation of the ipsilateral diaphragm. These signs may be quite helpful in pointing to the presence of retroperitoneal injury.

The intravenous pyelogram usually is the most informative examination in patients with renal injury. The early nephrogram phase is quite important as position and outline of the kidney can

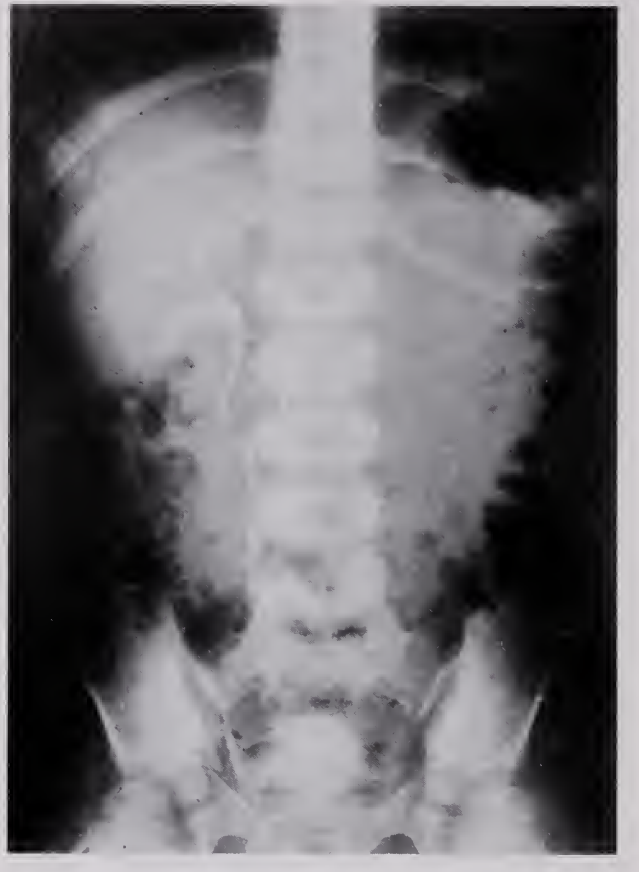

Fig. 3 Case #2. IVP—no function in left kidney.

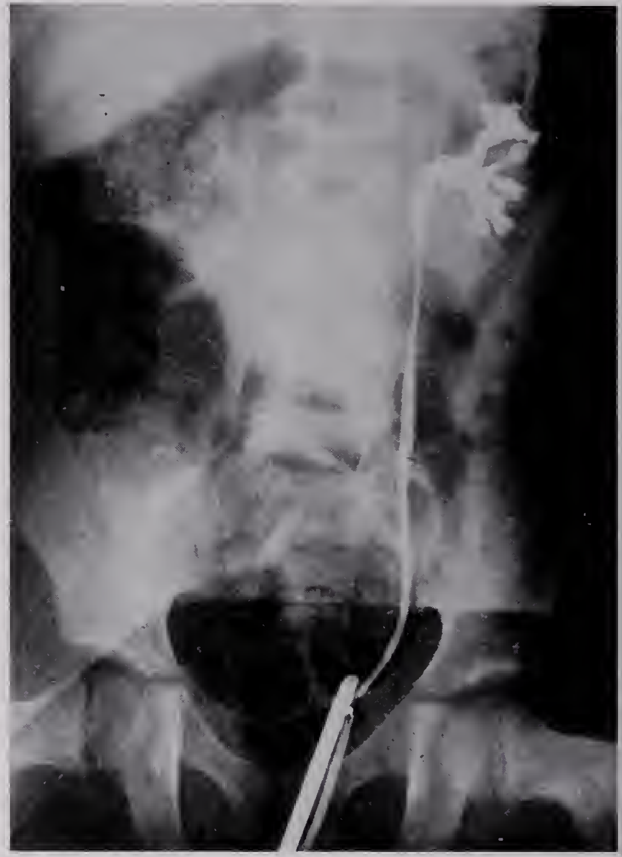

Fig. 4 Case #2. Retrograde pyelogram—normal left pyelogram.

suggest a perirenal collection of blood. Intrarenal hemorrhage may be manifest as an enlarged renal silhouette. Definite diminution in intensity of the nephrogram on the injured side as compared to the other kidney is good evidence of renal injury.

The remaining films of the intravenous examination also are quite important. Absence of excretion from one part of the kidney may indicate localized injury. One may see extravasation of contrast material beyond the confines of the calyces implying fracture of the kidney. Defects in the pelvis or ureter are quite suggestive of blood clot without giving information as to the precise extent of injury.[1]

It is extremely important to evaluate the condition of the contralateral kidney during the intravenous study.[2] This is vital if operation on the traumatized kidney is contemplated. One also may note underlying renal abnormalities such as chronic inflammatory changes, cyst, tumors or congenital deformities, all of which have a higher incidence of hematuria following trauma.

The use of retrograde pyelography for evaluation of renal trauma is open to dispute. During a retrograde examination, it is possible to dislodge a clot or increase the risk of infection in an injured kidney.[1] However, this study may be quite helpful as it is probably the best method for demonstrating the ureter and the renal pelvis and may yield information otherwise not obtainable.

The use of renal scans in recent years has been quite helpful in evaluating patients with question of renal injury.[2] The renal vascular flow as well as renal function can be evaluated rapidly and without morbidity.

Renal angiography has been utilized in an attempt to more definitively evaluate renal damage. The plain film, IVP, retrograde and scan may not disclose the full extent of injury. The angiogram yields accurate information concerning the renal vascularity and renal parenchyma. The findings are extremely helpful in establishing the extent of injury and extremely helpful in evaluating the necessity for operation.

In a series of 24 patients subjected to renal angiography, Elkin reported 13 positive angiograms with lesions ranging from thrombosis of a major or minor vessel to intra- or extra-renal hemorrhage or even fracture of the kidney.[1] Lang reported[3] a

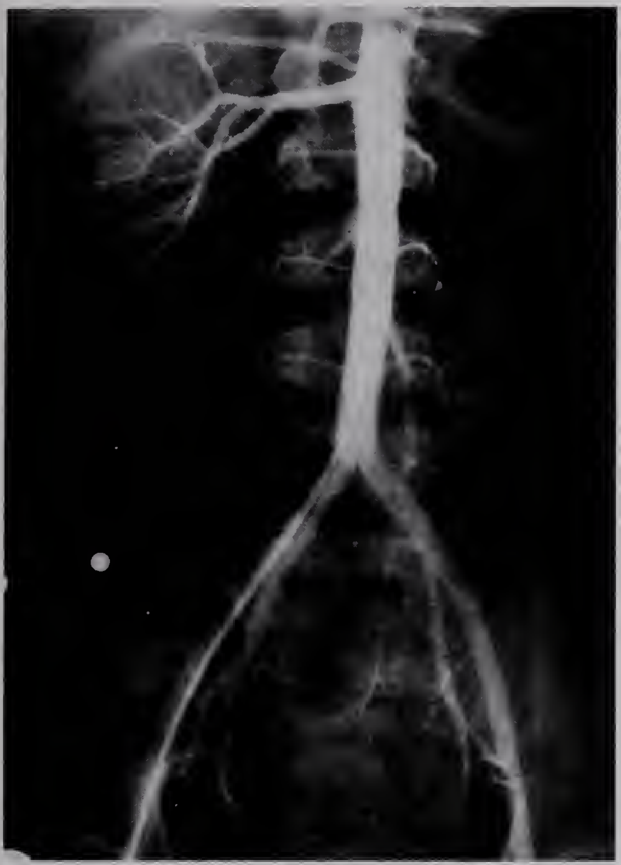

Fig. 5 Case #2. Aortogram with occlusion of left renal artery.

similar study. However, he emphasized six patients who had varying degrees of trauma but who did not have exploratory operations because of a negative angiogram. Without the angiogram in our first case, the diagnosis of congenital absence of the left kidney would have been difficult to make.

Described in both series of positive angiograms were three patients similar to our Patient #2. The renal workup, including intravenous pyelogram and angiograms, was delayed due to lack of hematuria or the presence of other major injuries requiring more immediate care. In all three cases, the kidneys were lost due to renal vascular infarction. These cases point to the need for *immediate evaluation of the genitourinary tract in abdominal trauma.* A delay of up to 48 hours may lead to a nonviable kidney.

SUMMARY

Prompt and complete evaluation of the genitourinary tract with abdominal trauma is definitely indicated in an attempt to evaluate the extent of renal injury and to prevent irreversible damage.

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Follicular Carcinoma

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Cooperation of physicians is asked in referral of patients with operable bone or soft tissue sarcoma to the Surgery Branch, National Cancer Institute, to enter into a randomized study of Warfarin anticoagulation and chemotherapy as adjunctive measures to surgical treatment. Patients must have no evidence of metastatic disease and must not have received chemotherapy, radiotherapy or surgery to the primary exclusive of biopsy or minimal local resection.

Physicians interested in further details and in having their patients considered for admission may write or telephone the Admitting Office, National Cancer Institute, Clinical Center, Room 10N119, National Institutes of Health, Bethesda, MD 20014. AC 301-496-2031.

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One Year's Experience With Respiratory Distress Syndrome at St. Louis Children's Hospital

THE PHENOMENON of the Neonatal Intensive Care Unit (NICU) has facilitated the management and study of infants with the Respiratory Distress Syndrome (RDS) so that survival rates have increased. The Hospital for Sick Children in Toronto had reported a 60% death rate from RDS prior to the opening of an NICU. The rate fell to 48% after the NICU began using only conventional intensive care and to 36% in 1967-1968 with the introduction of artificial ventilation.[1] At another institution, the overall mortality of neonates weighing between 1,001 gm and 1,500 gm has been halved and the birth weight associated with 50% mortality has dropped from 1,250 gm to 1,000 gm in the last decade.[2] An important factor in this progress has been the increased survival of severely affected RDS patients. A 71.5% survival rate has been reported in 49 severe RDS patients treated with continuous negative chest wall pressure,[3] and Gregory *et al*[4] have reported an 80% survival rate using continuous positive airway pressure (CPAP).

In an effort to evaluate the experience with RDS at the NICU of the St. Louis Children's Hospital, a retrospective chart review was undertaken. This study was useful in assessing the function of a young NICU in its third year of operation and its first full year of experience with the Bourns respirator, a positive pressure ventilator. It also was the first year under a full time director. A classification of severity of RDS using the initial chest x-ray was found to be useful.

A retrospective analysis of 125 cases of the respiratory distress syndrome with 63% survival is reported. The authors outline the problems associated with use of routine ambulance service in transporting neonates and the complications encountered in 45 patients ventilated with the Bourns respirator. The suggestion is made that a standard definition of severe RDS be made to include arterial blood gas data under known conditions and the radiographic stage. The authors are from the Departments of Pediatrics and Radiology, Washington University School of Medicine and the Division of Neonatology, St. Louis Children's Hospital. This research was supported by NIH Grant RR05389 and Illinois-Missouri Bistate Regional Medical Program Grant PC5.

PROCEDURE

Three hundred and fifty-four charts from patients admitted to the 12-bed NICU at St. Louis Children's Hospital between Sept. 30, 1971 and Oct. 1, 1972 were reviewed. Patients whose clinical course, chest roentgenograms, blood gas data and, when possible, autopsy findings were consistent with the diagnosis of RDS were selected for further analysis. All infants with the diagnosis of RDS were included in the study except eight patients with other serious lesions including Potter's syndrome (1), meningitis (1), erythroblastosis (1), multiple anomalies (1) and extreme prematurity (4).

Patients were classified as mild, moderate, moderately severe or severe RDS on the basis of their initial portable chest roentgenogram, using a modification of the scheme advanced by Wolfson *et al.*[5] Fig. 1 illustrates the four stages. Virtually all examinations were performed with portable battery-operated equipment with an exposure time of 1/120 seconds.

Our criteria for placing a baby on the respirator were (1) persistent apnea; (2) inability to maintain P_aO_2 above 50 mm Hg with 100% oxygen or (3) P_aCO_2 above 70 mm Hg despite frequent ventilation with a bag. Only infants who demonstrated a need for more than 40% oxygen had an umbilical artery catheter placed. All infants were transfers from other hospitals, and routine ambulance service was utilized. On admission, the babies in respiratory distress were given enough oxygen to relieve cyanosis prior to obtaining initial blood gases. One hundred percent oxygen, however, was not used routinely prior to initial blood gas determinations.

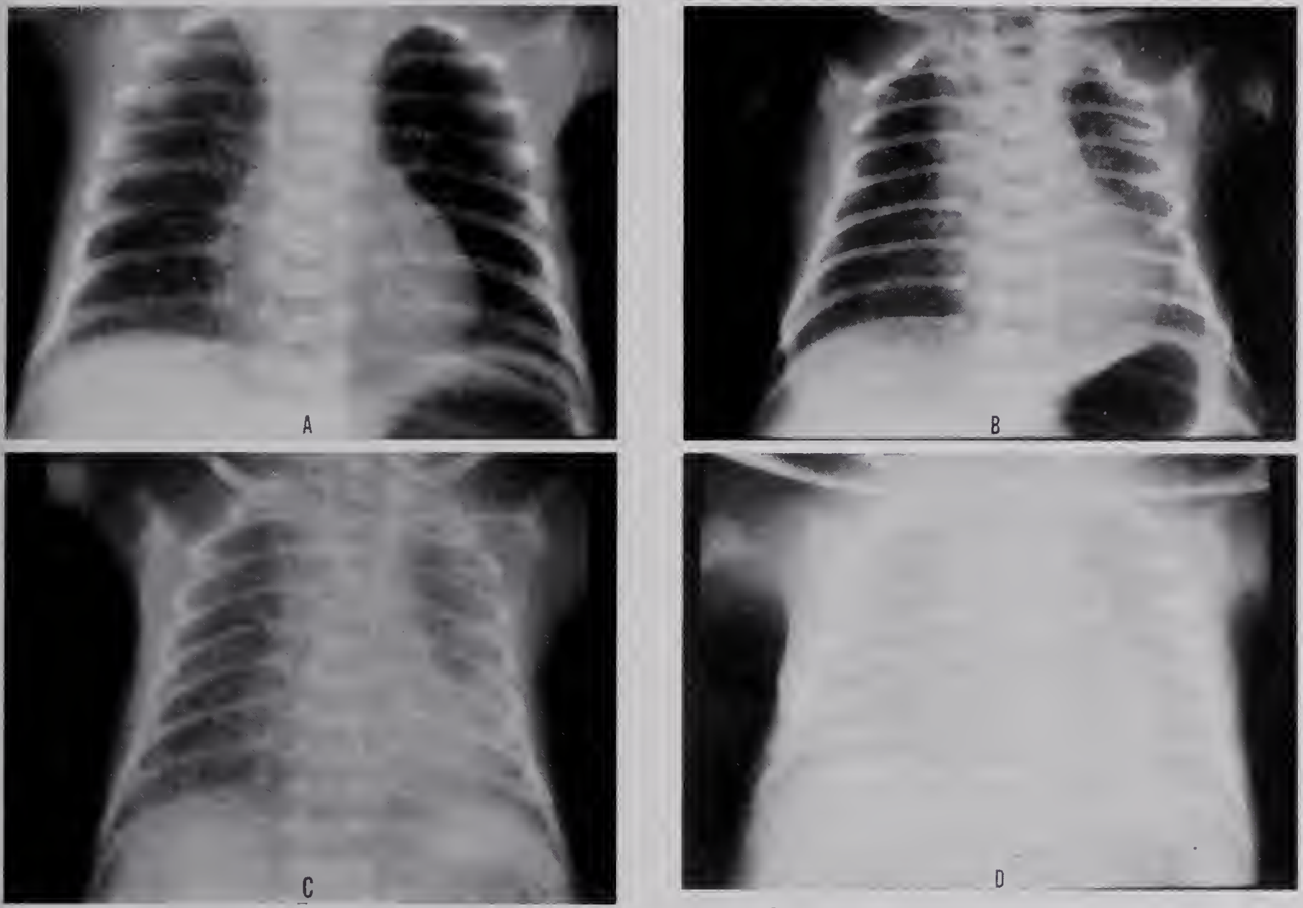

Fig. 1 Chest roentgenograms in the respiratory distress syndrome. (A) Stage I: Mild disease. Faint granular opacities with only occasional or no air bronchograms. (B) Stage II: Moderate disease. Granular opacities more pronounced, with numerous air bronchograms. May have scattered areas of coalescence. (C) Stage III: Moderately severe disease. Numerous areas of coalescent alveolar opacification amounting to not more than one half of the total lung fields. Air bronchograms present. (D) Stage IV: Severe disease. Alveolar opacification involving the majority of the total lung fields.

The data on RDS infants was abstracted on computer cards and analyzed by the Division of Biostatistics, Washington University.

Results

Two hundred and seventeen male infants and 137 female infants were admitted to the NICU during the year. The 125 patients (83 males and 42 females) with RDS comprised the most frequently encountered disease. Of the RDS babies, 81 were white, 43 were black and one was Oriental. On the basis of the Colorado Growth Chart,[6] 90 babies were Premature–Appropriate for Gestational Age (P-AGA); 25 were P-SGA; one was P-LGA; and 9 were Term-AGA. There were no T-SGA or T-LGA babies. Sixteen of the RDS neonates were twins.

One hundred and seventeen initial chest radiographs were independently evaluated by two observers who were unaware of the initial interpretations. Eight films were unavailable for review. No normal chest radiographs occurred. There were 25 patients in Stage I, 45 in Stage II, 25 in Stage III and 22 in Stage IV. On reevaluation, the two observers agreed in 85% of the cases concerning the stage of disease. When a disagreement existed, it always involved Stages II and III. The death rate, mean birth weight and mean gestational age in each of the four radiographic stages of RDS are depicted in Fig. 2. Of the total of 125 babies, 79 (63%) survived.

Twenty-seven infants were delivered by Caesarean sections, ten of which were repeat sections in women not in labor. Of these ten elective sections, only one mother had a lethicin/sphingomyelin ratio determined. None of these ten babies died. Six neonates delivered by Caesarean section died. Twenty-four of the 98 babies delivered vaginally were breech.

The infants with more distress tended to be transferred from the 22 referring hospitals at a

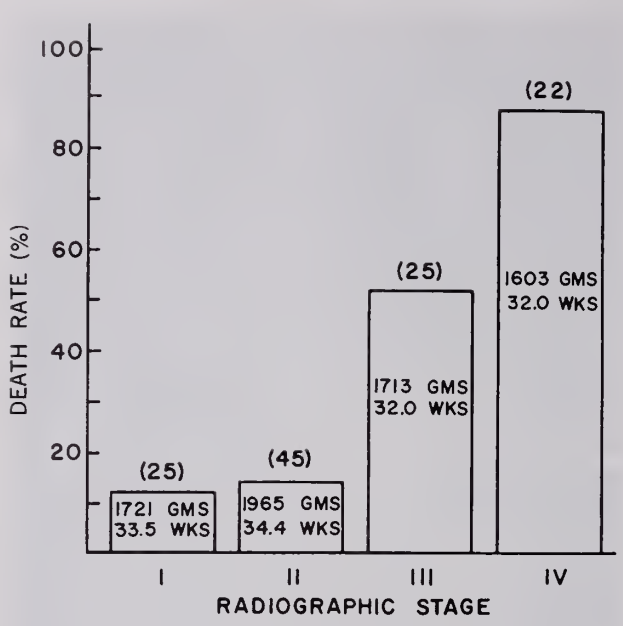

Fig. 2 Death rate of the four stages of RDS with the mean birth weight and gestational age of each group.

younger age. Sixty-three patients were admitted at less than five hours of age and 94 by nine hours. Fifty-six (45%) babies were transferred from hospitals located more than five miles away, the longest distance being 170 miles.

The condition of the babies on arrival is reflected in the vital signs on admission. Seventeen patients arrived with axillary temperatures below 35 C. Five patients had pulse rates below 100 per minute and five had no spontaneous respirations. It is widely appreciated that prematures are prone to hypoglycemia, and four patients in this series had serum glucose levels below 20 mg/100 ml on admission. However, overtreatment resulting in hyperglycemia, especially during transportation of the newborn, is not rare. Four patients had admission serum glucose levels greater than 230 mg/100 ml. All four hyperglycemic infants had umbilical vein catheters with dextrose solutions being infused during the transfer. One six-hour-old newborn arrived weighing 220 gm heavier than at birth after transfer over a distance of 70 miles during which a solution of 5% dextrose in water was being given intravenously. On arrival, his cerebrospinal fluid glucose was 290 mg/100 ml; serum glucose, 250 mg/100 ml; and serum sodium, 111 mEq/liter.

TABLE 1

COMPLICATIONS ENCOUNTERED WITH RESPIRATORY THERAPY IN 45 PATIENTS WITH SEVERE RDS

	Number of Patients
Bronchial or pulmonary infection	8
Subarachnoid hemorrhage (SAH) alone	16
Intraventricular hemorrhage (IVH)	14
Pneumothorax	12
Pneumomediastinum	9
Interstitial emphysema	24
Endotracheal tube displacement	
Main stem bronchus	12
Extubated accidentally	8
Plugged tube	4
Pulmonary hemorrhage	9
Tracheal erosion	2
Residual pulmonary disease (in 8 survivors)	3
Retrolental fibroplasia	0

Forty-five patients (36%) were treated with the Bourns positive pressure ventilator. Only eight (18%) of the babies survived. Twenty-three of 25 babies requiring the respirator before 24 hours died as compared to 14 of 20 ventilated after 24 hours of age. Of the 12 babies weighing more than 2,000 gm, five survived. The mean birth weight of the eight survivors of the respirator was 2,238 gm and of the 37 who died, 1,505 gm. Mean gestational age for survivors was 35.3 weeks as compared to 31.4 weeks for those who died. The problems encountered in respirator-treated RDS patients are listed in Table 1.

Every baby treated with oxygen had an ophthalmologic examination prior to discharge; no retrolental fibroplasia was recognized. Seven babies had inguinal hernias which were repaired without incident prior to discharge. Necrotizing enterocolitis (NEC) developed in six babies during treatment for RDS. Two were treated surgically and given total parenteral alimentation, whereas four were treated medically with antibiotics and nothing by mouth. Only one baby with NEC died. Nineteen patients were diagnosed as having a patent ductus arteriosus. During their neonatal course, 72 babies (58%) were clinically icteric (total bilirubin > 7 mg/100 ml), five were hypoglycemic (serum glucose < 20 mg/100 ml) and three were hypocalcemic (serum calcium < 7.0 mg/100 ml). Utilizing Chi square analysis, a number of variables were associated with fatal outcome (Table 2).

DISCUSSION

Despite the high incidence of RDS, there is a lack of universally accepted criteria to make the diagnosis.[7] Physicians usually diagnose the syndrome clinically. In addition to establishing the diagnosis in each infant, quantification of the severity of the disorder would be helpful. Various

TABLE 2

FACTORS ASSOCIATED WITH FATAL OUTCOME IN RDS

$p < 0.01$	*$p < 0.05$*	*Not Significant*
Low birth weight	Maternal bleeding during pregnancy	Sex
Young gestational age	Low admission temperature	Maternal age
Low apgar scores	Pneumothorax	Transfer distance
Young age on admission	Vaginal delivery	Admission P_aO_2
Low admission respiratory rate	Negro race	Admission CO_2
Stage IV RDS by x-ray on admission		Admission hematocrit
Low admission pH		Admission white blood count
Necessity for mechanical respirator		
Interstitial emphysema		
Low admission pulse		
CNS bleed		

criteria to grade severity of disease have been suggested. In 1956, Silverman published a chart suggesting that one could grade respiratory distress into stages 0, 1 or 2 based upon the degree of retraction and presence of grunting.[8] Miller divided RDS patients into two groups, those who needed supplemental oxygen to prevent cyanosis (severe) and those who did not need oxygen (mild).[9] Single or serial measurement of the P_aO_2 during breathing of 100% oxygen has recently served as a major determinant of the severity of RDS.[4, 10, 11]

The potential usefulness of the chest radiograph in detecting stages of severity of RDS was first reported in 1953 by Donald and Steiner.[12] They described the classical radiographic findings in RDS and suggested that a typical case progressed from a fine miliary mottling over the lung fields to air bronchograms and, finally, to confluent shadows. However, five of their 28 babies with RDS by chest radiographs did not have RDS at autopsy. Subsequent papers have clarified aspects of the radiographic diagnosis of RDS.[13-16]

Wolfson *et al* refined the classification of RDS by outlining four stages of severity discernible on the initial chest radiograph.[5] Although no clinical report has used this method of staging, we postulated that the addition of radiographic evidence possibly would add to the standardization of the term "severe RDS." A key factor in the increased reliability of the chest radiograph is new radiographic equipment capable of 1/120 second exposure which produces superior roentgenograms not duplicated by prior equipment.

In this retrospective study, the assignment of radiographic staging correlated well with the clinical and biochemical severity of the illness except in nine premature infants who tolerated mild or moderate RDS (stages I and II) poorly. As depicted in Fig. 2, the classification of an infant as stage I, II, III or IV RDS would be an important prognostic indicator. Although Stages I and II have almost identical death rates in this series, differences may appear in other NICUs with different modes of ventilatory assistance.

The radiographic staging of RDS may allow for better standardization in the clinical reporting of RDS patients. Present definitions of "severe" RDS are arbitrary and vary significantly from author to author. We would diagnose severe RDS in any newborn with the physical findings of tachypnea, grunting, retractions or repeated episodes of apnea who is unable to maintain a P_aO_2 greater than 50 mm Hg while breathing 100% oxygen and whose chest roentgenogram shows Stage III or Stage IV disease.

Many of the factors associated with an increased mortality have been reported.[9-11, 17] Several variables, however, deserve comment.

In our series, 40 of 98 (40%) vaginally delivered infants died compared to only six of 27 (22%) sectioned babies. This does not contradict the well-established increased death rate from RDS for babies delivered by section as compared to vaginal delivery for any given gestational age[17] because our sample included only RDS babies. The mean gestational age of our sectioned babies was 35.3 weeks. For babies of 35 to 36 weeks gestation, Usher *et al* have reported a mortality rate of 18.5%.[17]

Birth weight correlated negatively with mortality for radiographic Stages I-III ($p < 0.01$) but not significantly for Stage IV ($p > 0.05$). Babies with Stage IV RDS had a poor prognosis regardless of their size. In addition, babies who were lighter and younger were less able to tolerate Stages I-III RDS. Fourteen of 34 (41%) of babies with birth weights under 1,500 gm died with Stages I-III RDS as compared to seven of 61 (12%) of babies over 1,500 gm. Approximately the same percentages apply to babies of 33 weeks gestational age or less.

The death rate was 22 out of 43 black infants (51%) compared to 23 out of 81 white infants (28%). This difference is significant, $p < 0.05$. To help explain this, a significant difference was found between race in terms of gestational age ($p < 0.05$) with black babies being more premature. Black babies comprised 12 of 19 patients with gestational age of 29 weeks or less but only one of 13 patients of 37 weeks or more. It is possible that maternal health, availability or use of medical care or social class are factors which accounted for this difference in very premature babies and, hence, the increased mortality rate.

Patients with RDS who require a respirator within the first day of life have a poor prognosis.[18, 19] In this series, 24 of 26 such babies died. This very high mortality may be related to the fact that all of our patients are transfers from other hospitals and that the delay in initiating resuscitation procedures may be critical. In addition, we do not deny respirator therapy to even very immature neonates. All 14 patients with documented intraventricular hemorrhage (IVH) had been on the Bourns respirator, but the retrospective nature of the data precludes any statement about cause and effect. Additional prospective controlled studies with various types of mechanical ventilators are necessary to determine possible cause and effect relationships among respirator complications.

Although no deaths occurred in the ten babies delivered by elective Caesarean section, they all developed RDS. This points out a need for better understanding between obstetricians and pediatricians since the decision to terminate a pregnancy really involves *two* patients. The current development of high-risk prenatal clinics attended by obstetricians and neonatologists in university hospitals is a step in the right direction. More avenues of communication need to be developed on a day to day and on a community-wide basis.

As a result of our experience, we have initiated several measures to reduce the 37% death rate of our RDS babies. As noted above, the metabolic problems of hyper- and hypoglycemia, hypothermia, anoxia, overhydration, hyponatremia, acidosis and insipient or frank pulmonary failure were associated with the transfer of neonates to our hospital. We now have an infant transport service in effect whereby a pediatric house officer and an NICU nurse go to the referring hospital to pick up the patient. Secondly, we have begun earlier and more frequent use of CPAP as recommended by Gregory.[4] Third, we describe all admission radiographs in RDS patients in terms of stages and use this as one of our prognostic indicators. Fourth, despite a high death rate with respirator babies, we have not attributed this to the Bourns machine itself. Several babies have survived four to six weeks of respiratory therapy, and the equipment is easy to operate. We have adapted our respirators in order to add positive end expiratory pressure (PEEP). This has improved oxygenation in some babies in whom mechanical ventilation alone was inadequate. Finally, we are encouraging close cooperation among pediatricians and obstetricians in our referral region in the management of high risk pregnancies in order to prevent neonatal disorders like RDS.

SUMMARY

A retrospective analysis of 125 cases of RDS is reported with 63% survival. The problems associated with the use of routine ambulance service in transporting neonates and the complications encountered in 45 patients ventilated with the Bourns respirator are outlined. The usefulness of the initial chest roentgenogram in separating out four stages of RDS is described. The suggestion is made that a standard definition of severe RDS be made to include arterial blood gas data under known conditions and the radiographic stage.

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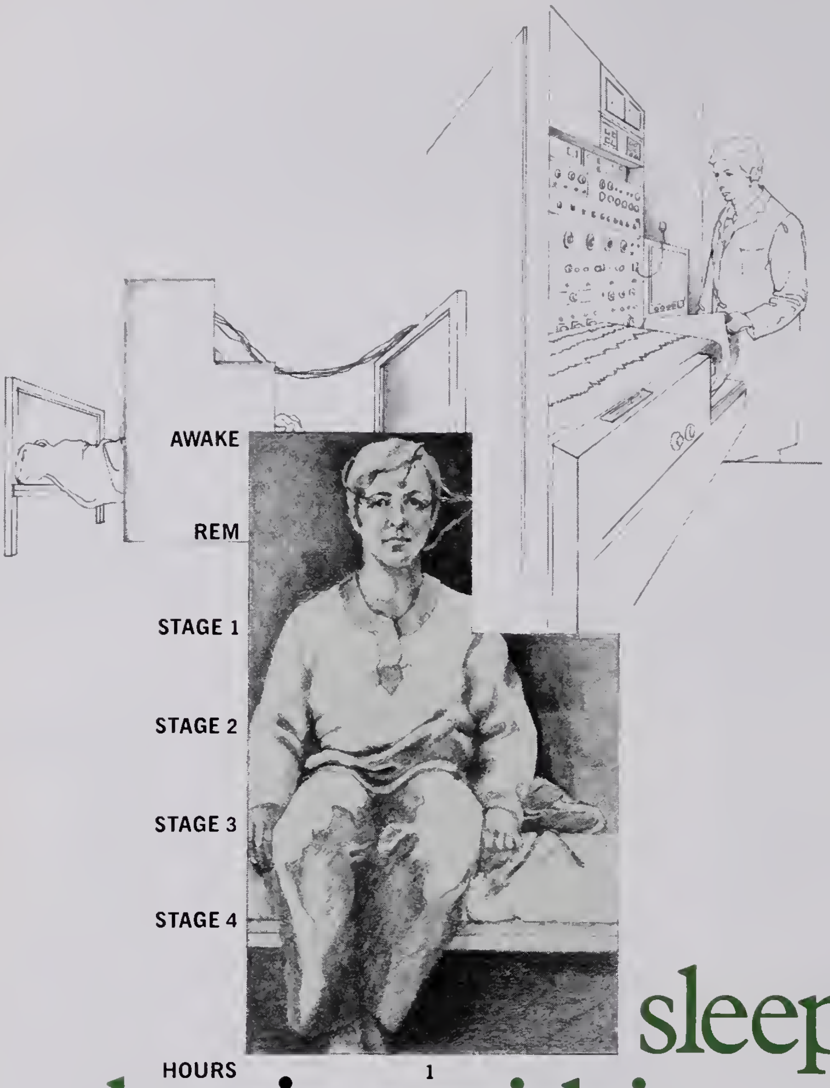

sleep begins within 17 minutes, on average...

an initial benefit of

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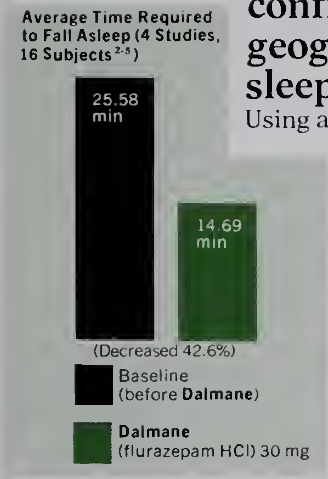
(flurazepam HCl) **proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home**[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

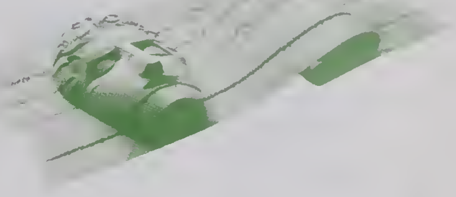
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®

(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

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Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
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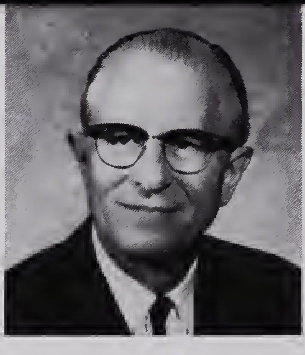

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

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should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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P·M·A

acute gonorrhea

This patient
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an effective, private,
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It took just one short visit...

*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
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Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae.* The usual dosage for Trobicin in adult males is 2 grams intramuscularly[†]; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular
..and **Trobicin**® 2 gm and 4 gm vials
sterile spectinomycin hydrochloride

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erile Trobicin (spectinomycin hydrochloride) For Intramuscular Injection:
gm vials containing 5 ml when reconstituted ith diluent.
gm vials containing 10 ml when reconstituted ith diluent.
n aminocyclitol antibiotic active *in vitro* against ast strains of *Neisseria gonorrhoeae* (MIC 7.5 20 mcg/ml). Definitive *in vitro* studies have own no cross resistance of *N. gonorrhoeae* etween spectinomycin and penicillin.

dications: Acute gonorrheal urethritis nd proctitis in the male and acute gonorrheal rvicitis and proctitis in the female when due susceptible strains of *N. gonorrhoeae.*

ontraindications: Contraindicated in pants previously found hypersensitive to spectinomycin.

arnings: Not indicated for the treatment of philis. Antibiotics used to treat gonorrhea ay mask or delay the symptoms of incubating philis. Patients should be carefully examined nd monthly serological follow-up for at least months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae.*

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—**Inject 5 ml intramuscularly** for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—**Inject 10 ml intramuscularly** for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae.*
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

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The Upjohn Company, Kalamazoo, Michigan 49001

[†] For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic esistance is known to be prevalent, initial treatment with 4 grams is preferred.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

[1] Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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President's Message

When controls were lifted on May 1, it was the first time in two years and eight months that a physician could exercise his ancient and traditional privilege of determining the value of his own services.

It is entirely possible or even probable that fees will be fixed again. When National Health Insurance becomes a reality, we may again expect price controls on our services. It is even possible that fees will be rolled back to the April 30, 1974 level before controls were lifted.

If, however, we assume that a physician will be allowed to set his fee after May 1, how high should these fees be raised?

There are two courses of action that may be mutually exclusive. It would be desirable to keep medical costs at a minimum, but it also is necessary to survive inflation.

Let not the American Doctor underrate himself. His education, by the time he finishes medical school, is equivalent to the Ph.D. or the Sc.D., the highest academic degrees attainable. In addition to this, he must have a minimum of one more year of training to enter practice. Should he choose to specialize, he will have another four or five years of training. To become Board Certified, he must pass another examination equivalent to the Doctoral Thesis. Most physicians will work 50 to 60 hours a week. The pay should be commensurate with the training and the amount of work, at least that of a major executive for a large corporation.

James C. Cope, M.D.

By keeping fees low, one runs the risk of again being trapped by a price freeze. By making a substantial increase, one adds to the inflationary spiral. It is a matter for reflection and personal judgment.

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Old World Odyssey includes a 7-day adventure cruise aboard the beautiful Sun Line ship STELLA SOLARIS, one of the finest cruise ships in the world today. You'll see the fabled Greek islands of Mykonos, Rhodes, Santorini, Crete, Delos, Ephessos and Istanbul in Turkey.

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Enclosed is my check for .... ($100 per person deposit) for the Old World Odyssey. I understand my deposit is fully refundable until 60 days prior to departure.

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I prefer non smoking section ☐

Stateroom assignments will be made in the order of receipt of deposit.

Single Supplement $215

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Limited Space Available

Woman's Auxiliary

50th Anniversary

LEGS! What is meant by this intriguing name? LEGS is a vital part of the Auxiliary program and is especially important to the physicians of the state and nation. **L**egislative **E**ffort **G**roup **S**ystem is the official title, but the real meaning is communication. When a crucial bill is being considered in Congress, the Legislative Chairman of the Woman's Auxiliary to the AMA contacts key people in every state auxiliary. These women, in turn, contact key people in every county auxiliary. These county people alert all members. Imagine the impact when all of these women respond by writing letters to their Congressmen!

Mrs. George J. Lytton
President

Legislative Affairs in our Missouri Auxiliary are in the capable hands of Mrs. Gerald L. Miller of Kansas City. She alerts the county auxiliaries as to the status of medically related bills introduced in both Missouri and on the national level.

Previous years have seen MSMA Auxiliary members from all over the state gathering in Jefferson City to visit the General Assembly. This year we are asking all county auxiliaries to conduct a local Legislative Day with the lawmakers and their wives as special guests. This will make for a more personal contact with the legislators from each community.

"Never underestimate the power of a woman" is an old saying. In this case, please don't underestimate the power of the LEGS line. It is one of our most effective ways of helping the physicians of Missouri.

EDITORIAL

SMOKESCREEN HAZARD TO HEALTH

Your medical records—from general health history to psychiatric diagnoses—may now be examined by government bureaucrats.

You and your personal physician may no longer decide that you should be admitted to a hospital—the government can decide that. And the bureaucrats can throw you out of a hospital despite the advice of your physician.

Your doctor may be fined $5,000 for deviating from federal procedures which describe exactly what may and may not be done regarding your own, unique health situation.

You and your physician will be part of a computerized file system which will establish certain "norms."

These are among the consequences of a law—already in effect—that establishes a massive network of "Professional Standards Review Organizations" (PSROs). The PSROs are now being deployed by Big Brother as a result of a little-considered amendment tacked onto a bill in 1972.

PSROs were presented as a way for doctors to examine the services performed by other physicians and to determine that these conformed to regional standards of medical practice. Yet the boards are primarily window-dressing; the law repeatedly states that procedures will be conducted "in accordance with the regulations of the secretary" of the U. S. Department of Health, Education and Welfare. The secretary's powers are listed 96 times in the law.

* * *

When HEW awarded its first PSROs contract this month (the program took effect Jan. 1 and will not be fully implemented until 1976), the administrator of the program boasted, "PSROs is potentially the most important piece of health legislation ever enacted, here or anywhere in the world. . . . The program has the potential now to be the backbone of all care rendered in the country to all citizens in any setting—hospital inpatients, office outpatients, and nursing homes."

The idea of federal bureaucrats in Washington setting "standards" for physicians regarding patient care is not much different than if the bureaucrats set "standards" for parents regarding their children's care. Who is better able to supervise the persons they care for—Washington functionaries or the family physician, the paper-pusher or the parent?

One reason the government is so interested in PSROs is the scandalous bureaucratic mess that followed the adoption of Medicare and Medicaid in 1965. These programs were "sold" with the assurance that they would not lead to federal control of medicine; in fact, the legislation stated that nothing in its language "shall be construed to authorize any federal officer or employe to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."

But now the government is arguing that PSROs and controls are necessary because of Medicare and Medicaid—thus justifying the federal control denied by the earlier programs. "The government is paying for a significant amount of medical care," said the HEW official in charge of the controls. "It wants to see that the care being received is appropriate."

Notice how the velvet glove becomes the iron fist? As would be the case with impending national health insurance proposals, and has been the case with virtually every federal program, the government's involvement with funding programs becomes the rationale for controlling them. With PSROs, subsidizing medical care has led to controlling medical care.

* * *

The PSROs legislation surely is, as an article in *The Wall Street Journal* calls it, "the most radical health legislation in this country's history." There is no other way to describe a law that imposes federal controls, grants the right to inspect an individual's highly personal medical history, fines doctors $5,000 plus the loss of the right to treat Medicare and Medicaid patients for deviating from federal procedures, and allows PSROs the right to order patients out of a hospital or deny admission altogether. Again, is your care a function of Big Brother or of your own physician?

How could Congress pass such a bill? The answer is: Unknowingly. The PSROs section was Section 249F of the 1972 Social Security Act amendments, which lingered on for 160 pages. The section was inserted by the Senate after the House had passed the bill, and was passed by the House as part of a House-Senate compromise bill without hearings and without most members even knowing the section existed.

There are more than 40 bills submitted in this Congress calling for repeal of the embryonic program. Eighteen state medical associations have formally urged repeal, and an equal number will soon consider such a resolution.

Those who think that national health care would be a great thing should ponder the lesson that PSROs already demonstrate: When federal funds for medical care are involved, controls over that medical care are close behind. It's true of medicine just as much as it's true of highways, education, flood insurance, welfare or anything else.

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The St. Louis Globe-Democrat
April 23, 1974

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

Dr. George E. Pierce, associate professor of surgery at Kansas University, presented the April 3 program of the Buchanan County Medical Society. His subject was "Current Concepts in Surgical Management of Tumors Metastatic to the Lung."

The annual Cancer Program was sponsored by the Buchanan County Unit of the Missouri Division, American Cancer Society. Dr. Randal E. Weed, President of the Medical Society, presided. Dr. Edward M. Beheler, Program Chairman, introduced the speaker.

Thirty-four members attended the dinner and program at the Hotel Robidoux in St. Joseph.

John T. Rogers, M.D., *Secretary*

Grand River Medical Society

The May meeting of the Grand River Medical Society was held on May 9 at the Strand Hotel in Chillicothe and was attended by 15 physicians and their wives.

The scientific program was provided by Donald Allcorn, M.D., professor in family practice, University of Missouri-Columbia. Dr. Allcorn presented an interesting talk on "Problem-Oriented Medical Records in the Office."

The scientific program was followed by a short business meeting at which it was decided to hold the June meeting on the second Thursday at the Country Club.

A letter from Dr. Fred D. Fowler, President of Jackson County Medical Society, regarding PSROs was presented to the Grand River Medical Society. It was voted to defer a decision in this matter until further clarification of the issues involved.

Members of the Woman's Auxiliary held a separate meeting.

George Mandler, M.D., *Secretary*

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Mineral Area Medical Society

The Mineral Area Medical Society met on April 11 at the Farmington Inn in Farmington with members of the Mineral Area District Osteopathic Association and Mineral Area Dental Study Group as special guests.

Those in attendance included some 38 physicians and dentists who gathered to hear Stanley S. Peterson, M.D. of Springfield, president of the American Federation of Physicians and Dentists and one of the MSMA's delegates to the American Medical Association. Dr. Peterson discussed medical unionism. The meeting was well attended and his presentation was well received.

There was no business meeting of the Medical Society.

C. W. Chastain, M.D., *Secretary*

Continuing Education Coming Events

June 5	**Seminar: Evaluation of Acute and Chronic Gastrointestinal Bleeding** The Ed Bixby Institute for Postgraduate Medical Education Research Hospital and Medical Center Kansas City
June 21-22	**Diagnosis of Bronchogenic Cancer With Emphasis on Early Lesions** Continuing Medical Education, M.U.-Columbia Lodge of the Four Seasons, Lake Ozark

Notice of Workshops on Federal Diagnostic X-ray Standards

A Federal standard for diagnostic x-ray equipment becomes effective August 1 of this year. This equipment standard primarily applies to manufacturers and assemblers but users also are affected.

Because the final standard was extensively revised and amended since first proposed in 1971, it is not surprising that many individuals affected are not yet knowledgeable about its full implications.

Under the standard, x-ray manufacturers are responsible for producing equipment and components that perform according to requirements of the standard. Assembler's primary responsibility is to install the system according to the manufacturer's specifications and to use the type of components called for by the standard. He must certify that these two conditions have been met by filing specified forms with the Food and Drug Administration's Bureau of Radiological Health, the State Radiation Control Agency and the purchaser.

One of the principal protection provisions of the standard requires machines to be capable of restricting the x-ray beam to the size of the film or fluoroscopic image receptor. The standard also contains provisions intended to make it possible for operators to reproduce more consistently a given image quality for given voltage, current and time settings. This capability, in combination with good x-ray examination techniques, will tend to minimize film retakes and unnecessary exposure.

To familiarize persons who are affected by the new standard, especially commercial installers and users who may perform their own installations, with their responsibilities under the new regulations, workshops are being conducted by the Food and Drug Administration. These one-day sessions are being held in various parts of the U. S. Workshops also will include discussions of proposed Federal requirements involving resale of used x-ray equipment.

Persons interested in attending are urged to contact the FDA Radiation Control Officer in their region for additional information:

Region V—(Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin):

Richard H. Cooke, Room A-1945, 175 West Jackson Blvd., Chicago, Ill. 60604. Telephone: 312-353-5244.

Region VII—(Iowa, Kansas, Missouri, Nebraska):

Donald R. Tillery, 1009 Cherry St., Kansas City, Mo. 64106. Telephone: 816-374-3817.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

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ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

ELLIS FISCHEL STATE CANCER HOSPITAL and the Associated CANCER RESEARCH CENTER

Semiannual Professional Program

Diagnosis, Treatment and Rehabilitation of the Head and Neck Cancer Patient

June 22, 1974 **Ramada Inn, Columbia**

8:30 AM Registration (no fee).

9:00 AM *Welcome,* Carlos Perez-Mesa, M.D., Chief Pathologist, EFSCH.

9:05 AM *Introduction,* Oscar N. Guerra, D.D.S., Chief of Maxillofacial Prosthetics, EFSCH.

9:10 AM *Epidemiology of Lesions of the Head and Neck Area,* Frank Watson, Ph.D., Director, Department of Biomathematics, CRC.

9:25 AM *Axioms of Cancer Treatment,* W. R. Hyatt, D.D.S., Professor and Chairman, Department of Hospital Dentistry, Kansas City General Hospital and Medical Center.

10:20 AM Coffee Break

10:40 AM *The Problems Involved in Early Recognition of Oral Cancer,* William G. Shafer, D.D.S., Professor and Chairman, Department of Oral Pathology, Indiana University-Purdue University.

11:35 AM Questions.

12 NOON Luncheon.
Observations of a Laryngectomee, Russell Rouse, President, Mid-Missouri Nu-Voice Club.

1:15 PM *The Role of Dentistry in Treatment and Rehabilitation,* James B. Lepley, D.D.S., Chief, Dental Service, Memorial Hospital for Cancer and Allied Diseases, New York, N. Y.

2:10 PM *Radiotherapy to the Head and Neck Area,* James Thomson, M.D., Chief, Department of Radiotherapy, EFSCH.

2:45 PM *Control of Complications Related to Head and Neck Surgery,* Alfred Ketcham, M.D., Clinical Director and Chief, Surgery Branch, National Cancer Institute, Bethesda, Md.

3:30 PM Coffee Break.

3:40 PM *Regional Chemotherapy to the Head and Neck,* William Donegan, M.D., Surgeon, EFSCH.

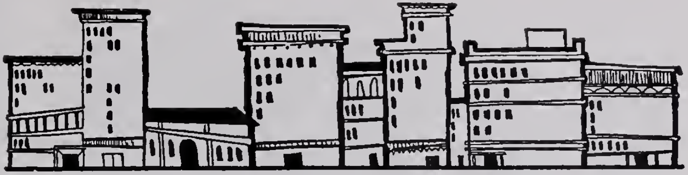
4:10 PM Questions.

4:30 PM Adjourn.

The EFSCH-CRC Professional Program is open to any interested health professional. Application has been made for five elective AAFP credit hours. For additional information, write to Oscar Guerra, D.D.S. or Hugh S. Harris, Jr., M.D., Ellis Fischel State Cancer Hospital, Business 70 and Garth Ave., Columbia, Mo. 65201.

This program is sponsored in part by the John Modlin Memorial Lecture Fund and the Harry M. Dawdy Fund established at the Cancer Research Center.

From the Medical Schools



WASHINGTON UNIVERSITY

Brain damage, resulting from diets deficient in Vitamin E, will be studied by a Washington University School of Medicine scientist with a $98,817 Department of Health, Education and Welfare grant.

James S. Nelson, M.D., associate professor of pathology and of pediatrics, is directing the investigation. "Nutritional disturbances are associated with a number of nervous system disorders in humans, especially children," he said. "But the process by which diet deficiencies lead to brain damage is incompletely understood."

This research is related to studies by others in the Division of Pediatric Neurology on the effects of nutritional deficiency on the central nervous system.

Philip Needleman, Ph.D., associate professor of pharmacology at the School of Medicine, has received Eli Lilly and Company's John J. Abel Award for independent and original research by an investigator under the age of 36.

Dr. Needleman was honored for his investigation of drugs used in the treatment of angina pectoris. His research also included work on the cause and treatment of hypertension and shock.

The award, a bronze medal and $1,000 honorarium, is given to stimulate fundamental research in pharmacology and experimental therapeutics by young investigators. Presentation was made on April 10 at the American Society for Pharmacology and Experimental Therapeutics banquet at Atlantic City.

UNIVERSITY OF MISSOURI-COLUMBIA

Dr. Murray Heimberg, now professor of pharmacology at Vanderbilt University, Nashville, will become the new chairman of the Department of Pharmacology at the School of Medicine, University of Missouri-Columbia on July 1, *Dean William D. Mayer* has announced.

Dr. Heimberg, 49, holds both Ph.D. and M.D. degrees and also will have an appointment in the Department of Medicine. His specialties are in endocrine and metabolic pharmacology and cardiovascular pharmacology. He has done extensive research for scientific papers, many dealing with the metabolism of triglycerides or with hepatic lipid metabolism in experimental diabetes. He has been an invited lecturer at numerous scientific meetings both in the United States and abroad.

Dr. Robert L. Russell has been acting chairman of UMC's Department of Pharmacology since Dr. Leslie Eisenbrandt's retirement.

The Muscular Dystrophy Association of America has designated the University of Missouri-Columbia Medical Center as a new clinic for its patient and community services program, *Warren Conner,* president of the Central Missouri chapter, has announced.

May 24 was the opening date of the clinic in the Howard A. Rusk Rehabilitation Center located in McHaney Hall, adjacent to the Medical Center. This is headquarters for outpatient services and a 60-bed in-patient service of the department of physical medicine and rehabilitation.

The regional Muscular Dystrophy Clinic will serve patients from a 23 county area of central Missouri. MDAA pays for all authorized services including diagnostic services, pertinent laboratory tests, orthopedic appliances, physical therapy and transportation costs to the clinic.

ST. LOUIS UNIVERSITY

A testimonial dinner honoring *Dr. G. O. Broun, Sr.,* was held at the University Club on April 25 at which the announcement of the establishment of the Goronwy O. Broun professorship of internal medicine at the St. Louis University School of Medicine was made by *Rev. Paul C. Reinert, S.J.,* University president.

In announcing the professorship, Father Reinert cited Dr. Broun's 50 years of dedicated service to the University as a faculty member at the School of Medicine.

After-dinner greetings extended to Dr. Broun were from the School of Medicine by *Dr. Robert H. Felix,* dean; from the trustees by *Mr. Ben F. Jackson,* chairman, Medical Center Trustees Committee; from the Jesuit Community by *Rev. Edward J. Drummond, S.J.,* Executive Vice President;

from the American Medical Association by *Dr. Hubert A. Ritter,* AMA delegate; from the Medical Center by *Dr. George E. Thoma,* Vice President for the University's Medical Center, who paid tribute to Dr. Broun as a teacher and friend.

Dr. R. Emmett Kelly was the master of ceremonies. Gathering for the affair were members of the Broun family, physician friends, faculty and University administrators.

At a medical seminar titled "The Next Half Century in Medicine—a Look Ahead" held earlier that day, Dr. Broun received two standing ovations. A capacity crowd of physicians, nursing administrators and medical students attended.

Panelists and their topics included *Dr. Theodore Cooper,* director of the National Heart and Lung Institute, National Institutes of Health, Bethesda, "Basic Research"; *Dr. William R. Danforth,* chancellor, Washington University, St. Louis, "Education"; and *Dr. Thoma,* "Health Care Delivery Systems." *Dr. Robert H. Felix,* dean, School of Medicine, was moderator of the session.

Dr. Broun, professor and director emeritus of the department of internal medicine and dean emeritus of the School of Medicine, is currently the director of the Outpatient Department of the St. Louis University Hospitals.

UNIVERSITY OF MISSOURI-KANSAS CITY

The University of Missouri-Kansas City (UMKC) is scheduled to take possession of its new building on Hospital Hill at the end of June. Designed specifically to support the programs of the School, the completed building represents the results of five years of work and the expenditure of more than $13 million.

The building, which contains 230,000 square feet, is located on Hospital Hill immediately adjacent to the UMKC School of Dentistry, the new Children's Mercy Hospital, the existing Kansas City General Hospital, the Western Missouri Mental Center and the Brothers of Mercy Extended Care facility. The building is designed to tie in on a floor-by-floor level to the new Truman Medical Center which is also under construction. This $35 million hospital will replace the present building of the Kansas City General Hospital which was constructed in 1905.

The Medical School building has five floors. Each of the upper two floors provides the facilities for four Docent Teams. Each of these two Docent floors in the Medical School building will be immediately adjacent to ambulatory and inpatient care facilities for that Docent Team in the new Truman Medical Center.

The third floor of the Medical School building is devoted entirely to research laboratories and animal quarters. The second floor is devoted entirely to biomedical communications and information sciences. The other half of the second floor houses an extensive television and audiovisual facility. Two living theaters and one lecture room are

(Continued on page 299)

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New Members

Neva P. Arribas, M.D., 4989 Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Arribas is a native of the Philippines, received his preliminary education at the University of the Philippines and his M.D. degree at Manila Central University, in 1954. He specializes in ophthalmology.

C. Boonkham, M.D., 9385 Page, St. Louis, has become a member of St. Louis Medical Society. Dr. Boonkham is a native of Thailand, received his preliminary education at Chulalongkorn University and his M.D. degree at Siriras Medical in 1968. He specializes in internal medicine.

James H. Butt, M.D., 800 Stadium Blvd., Columbia, has become a member of Boone County Medical Society. Dr. Butt is a native of Portsmouth, Ohio, received his preliminary education at Northwestern University and his M.D. degree at Western Reserve University in 1959. He specializes in internal medicine.

Gerard M. Callaghan, M.D., 1035 Bellevue, St. Louis, has become a member of St. Louis Medical Society. Dr. Callaghan is a native of the United Kingdom and received his M.D. degree at Glasgow University in 1967. He specializes in obstetrics and gynecology.

Dipak Chowdhury, M.D., 17221 E. 23rd, Independence, has become a member of Jackson County Medical Society. Dr. Chowdhury is a native of India, received his preliminary education at St. Edmund's College and his M.D. degree at the University of Calcutta in 1964. He specializes in internal medicine.

Clarence A. DeLima, M.D., 803 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. DeLima is a native of India, received his preliminary education at the University of Bombay and his M.D. degree at the University of Bombay in 1964. He specializes in psychiatry.

Thomas A. Dew, M.D., 114 N. Taylor, St. Louis, has become a member of St. Louis Medical Society. Dr. Dew is a native of Missouri, received his preliminary education at Arkansas A & M College and his M.D. degree at the University of Arkansas in 1967. He specializes in internal medicine.

Uma R. Eachempati, M.D., 14499 Ladue Rd., Chesterfield, has become a member of St. Louis Medical Society. Dr. Eachempati is a native of India, received her preliminary education at Madias, India and her M.D. degree at Osmania Medical College in 1959. She specializes in obstetrics and gynecology.

Thomas E. Ford, M.D., 615 S. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Ford is a native of Missouri, received his preliminary education at the University of Illinois and his M.D. degree at the University of Missouri-Columbia in 1971. He specializes in cardiology.

Gael R. Frank, M.D., 4240 Blue Ridge Blvd., Kansas City, has become a member of Jackson County Medical Society. Dr. Frank is a native of Manhattan, Kan., received his preliminary education at Kansas State University and his M.D. degree at Northwestern University in 1955. He specializes in orthopedic surgery.

Frederick E. Fried, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Fried is a native of New York, N. Y., received his preliminary education at the University of Pittsburgh and his M.D. degree at the Universiy of Lausanne in 1966. He specializes in psychiatry.

Joel S. Grossman, M.D., 24th & Cherry, Kansas City, has become a member of Jackson County Medical Society. Dr. Grossman is a native of Montreal, Canada, received his preliminary education at Pennsylvania State University and his M.D. degree at Jefferson Medical College in 1967. He specializes in radiology.

David A. Hardy, M.D., 1035 Bellevue, St. Louis, has become a member of St. Louis Medical Society. Dr. Hardy is a native of St. Louis, received his preliminary education at Brown University and his M.D. degree at Washington University in 1964. He specializes in urology.

David W. Keller, M.D., 4911 Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Keller is a native of New York, received his preliminary education at Canisius College and his M.D. degree at the University of New York in 1964. He specializes in obstetrics and gynecology.

Rosalyn Lepley, M.D., 735 Brittany Lane, St. Louis, has become a member of St. Louis Medical

Society. Dr. Lepley is a native of California, received her preliminary education at the University of California and her M.D. degree at the University of Minnesota in 1967. She specializes in family practice.

Stephen B. Lillard, D.O., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Lillard is a native of Philadelphia, Pa., received his preliminary education at the University of Missouri-Columbia and his M.D. degree at Kansas City College of Osteopathic Medicine in 1970. He specializes in anesthesiology.

P. Limpatakmonkol, M.D., 12091 Gist Park Dr., Bridgeton, has become a member of St. Louis Medical Society. Dr. Limpatakmonkol is a native of Thailand, received his preliminary education at Assumption College and his M.D. degree at Chiang Mai University in 1970. He is a resident in surgery.

M. S. Mathew, M.D., 1274 Rogue River Ct., Chesterfield, has become a member of St. Louis Medical Society. Dr. Mathew is a native of India, received his preliminary education at Travancore University and his M.D. degree at R. G. Kar Medical College in 1959. He specializes in psychiatry.

Edgardo G. Mayuga, M.D., 6420 Clayton Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Mayuga is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1960. He specializes in anesthesiology.

P. Moolsintong, M.D., 8167 Briarhaven, St. Louis, has become a member of St. Louis Medical Society. Dr. Moolsintong is a native of Thailand, received his preliminary education at Triam Udom School and his M.D. degree at Chulalongkorn Medical School in 1970. He is a resident in surgery.

Lester J. Nathan, M.D., 777 S. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Nathan is a native of Nebraska, received his preliminary education at the University of Omaha and his M.D. degree at the University of Omaha in 1952. He specializes in general surgery.

Edward J. O'Brien, M.D., 6150 Oakland, St. Louis, has become a member of St. Louis Medical Society. Dr. O'Brien is a native of Massachusetts, received his preliminary education at Boston College and his M.D. degree at St. Louis University in 1967. He specializes in radiology.

Prasert Punhong, M.D., 3658 W. Pine, St. Louis, has become a member of St. Louis Medical Society.

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Dr. Punhong is a native of Thailand, received his M.D. degree at Chieng Mai Medical School in 1970. He is a resident in surgery.

S. N. Rao, M.D., 5400 Arsenal, St. Louis, has become a member of St. Louis Medical Society. Dr. Rao is a native of India, received his preliminary education at St. Philomena's College and his M.D. degree at Mysore Medical College in 1964. He specializes in psychiatry.

Anthony J. Rejent, M.D., 4211 Bayless, St. Louis, has become a member of St. Louis Medical Society. Dr. Rejent is a native of Ohio, received his preliminary education at St. Louis University and his M.D. degree at Creighton University in 1964. He specializes in pediatrics.

George O. Sertl, M.D., 10757 Forest Path, St. Louis, has become a member of St. Louis Medical Society. Dr. Sertl is a native of St. Louis, received his preliminary education a St. Louis University and his M.D. degree at St. Louis University in 1967. He is a resident in orthopedics.

Jitendra P. Shah, M.D., 2034 Lafayette, St. Louis, has become a member of St. Louis Medical Society. Dr. Shah is a native of India, received his preliminary education at Presidency College and his M.D. degree at Medical College in Calcutta in 1970. He is a resident in urology.

Vicente T. NG Tsai, M.D., 1726-D E. Broadway, Columbia, has become a member of Boone County Medical Society. Dr. Tsai is a native of the Philippines, received his preliminary education at Far Eastern University and his M.D. degree at Far Eastern University in 1967. He specializes in plastic surgery.

S. Vidheecharoen, M.D., 1225 Graham Rd., Florissant, has become a member of St. Louis Medical Society. Dr. Vidheecharoen is a native of Thailand, received his preliminary education at Chulalongkorn University and his M.D. degree at the University of Medical Sciences at Siriraj Hospital in 1966. He specializes in general surgery.

William Vigor, M.D., 1035 Bellevue, St. Louis, has become a member of St. Louis Medical Society. Dr. Vigor is a native of Ohio, received his preliminary education at Ohio Wesleyan University and his M.D. degree at the University of Cincinnati in 1966. He specializes in plastic surgery.

H. Robert Willis, M.D., 216 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Willis is a native of Washington, D.C., received his preliminary education at Washington University and Colorado University and his M.D. degree at Colorado University in 1968. He is a resident in general surgery.

Darrel W. Yates, M.D., 2821 N. Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Yates is a native of Missouri, received his preliminary education at Southwest Missouri State University and his M.D. degree at the University of Missouri in 1967. He specializes in radiology.

In Memoriam

Howard Carter, M.D., Hamilton, a graduate of the University of Iowa, 1951; member of Grand River Medical Society; age 59; died April 14, 1974.

Albert M. Estes, M.D., 714 Broadway, Cape Girardeau, a graduate of St. Louis University, 1930; member of Cape Girardeau County Medical Society; age 73; died April 18, 1974.

John D. Maddox, M.D., 6th and Pearl, Joplin, a graduate of Washington University, 1933; member of Jasper County Medical Society; age 65; died April 19, 1974.

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Missouri Medicine in Review

FORTY YEARS AGO

Dr. William Henry Welch, dean of American medicine, died on April 30, 1934 at the age of 84 in the Brady Urological Institute of the Johns Hopkins Hospital in the foundation of which this internationally known educator played a major part.

Dr. Welch received his Bachelor of Arts degree at Yale University and graduated in medicine at the College of Physicians and Surgeons, Columbia University in New York. He isolated the organism causing gas gangrene, the old-time foe of surgeons. It is known as the Welch Bacillus.

Aside from his innumerable contributions to American medicine, Dr. Welch, above all others, was the greatest stimulus and incentive to other men and was responsible for the development of many notable figures in American pathology and medicine who were inspired by his teaching.

No physician has ever received more honorary memberships in different universities throughout the world, and it is doubtful if any physician has ever held as many offices.

On his 80th birthday, which was celebrated throughout the world, President Herbert Hoover proclaimed that "more than any other American, he has contributed to the relief of human suffering and pain."

TWENTY-FIVE YEARS AGO

The American Medical Association has announced approval of a residency specifically designed to train family doctors and new requirements for approval of hospitals for intern training. Previously, the AMA Council on Medical Education and Hospitals had approved hospitals for general or mixed residencies, which were rather loosely organized training programs for the purpose of providing additional experience following internship.

The residency for general practice will provide supervised training in the four major clinical divisions—internal medicine, surgery, obstetrics and gynecology and pediatrics—as well as in the auxiliary services of anesthesiology, pathology and radiology. Some 870 hospitals which the Council had previously accredited for general residency training will be expected to reorganize their programs in accordance with the new requirements for the general practice residency.

For the first time, the Council suggested a method for determining the number of interns to be appointed. The bed capacity of the hospital is used as a basis, with a range of 15 to 25 beds per intern recommended. Estimates indicate that 1,380 hospitals can meet the present quantitative requirements set up by the Council and, hence, have standards for approval by the Council.

TEN YEARS AGO

The St. Louis University Medical Alumni Association honored 16 past-presidents at a reception held in the Stockholm Room of the Chase-Park Plaza Hotel on March 10. Medical Alumni, faculty and wives attended the affair. Past-presidents in attendance for the honor ceremony were Drs. James P. Murphy, Matthew W. Weis, Jerome I. Simon, Alphonse M. McMahon, Daniel L. Sexton, Cyrus E. Burford, Lawrence M. Riordan, Helmuth H. Kramolowsky and Ralph A. Kinsella, Sr., all of St. Louis.

Past-Presidents of the Medical Alumni Association who were unable to attend were Drs. Garold V. Stryker, Venice, Fla.; Thomas J. Coogan, Chicago; Thomas F. Reilly, Springfield, Mass.; Lowell S. Goin, Los Angeles; and Edward H. McCormick, Toledo, Ohio. Dr. Fred W. Bailey received the award posthumously.

Missouri's three medical schools were presented checks totalling approximately $35,000 by the American Medical Association Education and Research Foundation at a luncheon at the University Club in St. Louis on April 15. Leonard T. Furlow, M.D., St. Louis, President of the MSMA, presented the grants to the deans of the medical schools.

Medical Schools

(Continued from page 294)

provided as major features of the first floor. These three major rooms are designed to bring together all necessary human and audiovisual resources for both medical education and continuing education programs.

The building design emphasizes television and audiovisual facilities in the belief that these will contribute increasingly to medical student education and to continuing education for physicians throughout the state. The intent is to make these facilities as widely available as possible by cooperating with physicians and specialty groups wherever possible in the development of continuing education programs.

The remaining portion of the first floor is divided between the Dean's Office and the mechanical equipment necessary to power, heat and cool the building. The basement level of the building contains an electron microscopy suite, mechanical equipment and storage space.

The time schedule is to move into the new building at the end of June and to have the building ready for the additional students who will begin their studies in Year 3 of the six-year program at the end of August. Members of MSMA are invited to plan and visit the new school and new building.

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Special Report:

ACTIONS and EVENTS
of the
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116th
ANNUAL SESSION

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117th MSMA Annual Session
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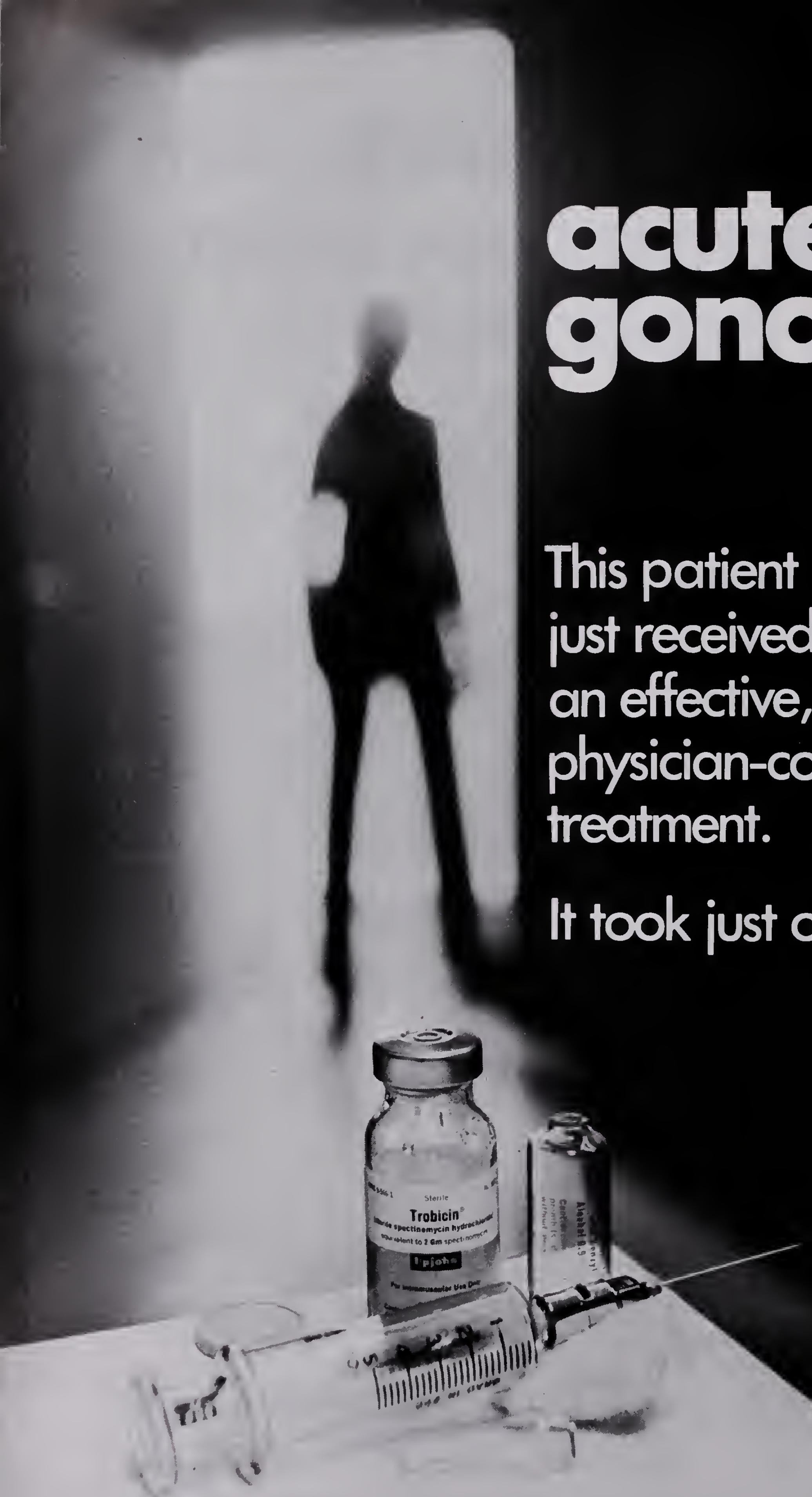

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Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9%* w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Caution: Federal law prohibits dispensing without prescription.

For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-I)
The Upjohn Company, Kalamazoo, Michigan 49001

[†]r patients with gonorrheal proctitis and for patients in geographic areas where antibiotic istance is known to be prevalent, initial treatment with 4 grams is preferred.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator… no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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MSMA
MISSOURI STATE MEDICAL ASSOCIATION
NEWS
ROUND - UP
JULY, 1974

AMA to seek PSRO amendments

The AMA House of Delegates voted at the 1974 Annual Session to direct the AMA's efforts toward constructive amendments of the PSRO law and to seek appropriate regulations and directives.

Following 4½ hours of hotly-contested debate in a Reference Committee ranging from calls for repeal of PSRO to pleas for abiding by the present law, the House made short work of the issue of the floor.

When the PSRO question was presented by the Reference Committee, the House voted to immediately end floor debate and vote on the substitute resolution offered by the Reference Committee. The Committee's substitute was approved by a wide margin, 185 to 57.

Discussion of PSRO has dominated the past three AMA Conventions and Delegates apparently felt that further floor debate would change few minds. During the lengthy Reference Committee hearing, reports on PSRO issued by the AMA Board of Trustees and the AMA's Council on Medical Service were considered along with 25 resolutions on the subject.

A copy of the AMA resolution concerning PSRO is included in this issue.

Perhaps the other hottest item at the Convention was the change in method for electing members to the AMA Board of Trustees and, later, the replacing of two incumbent Trustees with newcomers.

Previously, Trustees filed for a specific "slot" on the Board, thus eliminating the possibility that incumbents would face each other in an election. The prevailing floor debate claimed the "slot" system perpetuated incumbents.

On a one-sided vote, the House changed the method of Trustee selection to "simultaneous" elections. By this method, all candidates for the Board are listed on one ballot. Delegates then select one candidate for each position available. Any candidate who receives a majority of votes cast is elected. If all the Board positions are not filled, the candidate with the lowest vote total is dropped from the ballot and Delegates again mark their selections. This process is continued until the available positions are filled.

Whereas at previous Conventions balloting took little time, it was obvious from the start that Delegates had a long afternoon ahead of them in Chicago.

With 11 candidates seeking six Trustee posts, only two Trustees were elected on the first round. Approximately three hours later, balloting ended as all positions were filled.

(Continued on next page)

AMA's stand on PSRO

Resolved, *That this House of Delegates instruct the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to ensure appropriate regulations and directives, with particular effort directed at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further*

Resolved, *That the Association should continue its efforts to achieve legislation which allows the profession to perform peer review in accordance with the profession's philosophy and the best interests of the patient; and be it further*

Resolved, *That individual state associations which elect non-participation shall not be precluded from such a position by this Association's policy statement, but should be urged to develop effective non-PSRO review programs which embody the principles endorsed by the profession as constructive alternatives to PSRO; and be it further*

Resolved, *That if ongoing evaluation of the PSRO program reveals that it does, in fact, adversely affect the quality of patient care, or conflict with Association policy, the Board of Trustees be instructed to use all legal and legislative means to rectify these shortcomings.*

AMA actions

(Continued from previous page)

Elected to the Board was one incumbent, Dr. Raymond T. Holden of Washington, D.C.; and five newcomers, Drs. James Blake, New York; Daniel Cloud, Arizona; Frank Jirka, Illinois; Hoyt Gardner, Kentucky; and Joe T. Nelson, Texas.

Incumbents not re-elected were John M. Chenault, Alabama, and Donald E. Wood, Indiana.

In a pitched battle for President-Elect of the AMA, Dr. Max H. Parrott, a Trustee from Oregon, defeated Dr. Richard S. Wilbur, former Deputy Executive Vice President of the AMA, by a reported two votes of 240 cast, 121 to 119. Wilbur recently resigned from his post at the AMA following the Board's selection of Dr. James Sammons as Executive Vice President-Designate of the AMA to succeed Dr. E. B. Howard.

Dr. Malcolm C. Todd of California was installed as President of the Association during the meeting. He succeeds Dr. Russell B. Roth of Pennsylvania.

In the reorganizational meeting following the elections, the Board selected Drs. Richard E. Palmer, Virginia, as Chairman; Ray Holden, as Vice Chairman; and John H. Budd, Ohio, as Secretary-Treasurer. The Executive Committee consists of Drs. Palmer, Holden, Todd, Parrott, Gardner and Robert Hunter, Washington.

In other elections of interest, Dr. Joseph M. White, Jr., of Columbia, was re-elected to the AMA Council on Medical Education.

Dr. Hector W. Benoit, Jr., of Kansas City, who resigned from the AMA Council on Medical Service for personal reasons, was replaced by Dr. Robert T. Kelly from Minnesota.

The Resolution offered by the MSMA House of Delegates calling for "Coordination of AMA-ERF Fund Recipient with Practicing Physician" was lauded for its intent. The issue was referred to the AMA-ERF Board of Directors for study and recommendation.

MSMA Malpractice Study

The Rollins Burdick Hunter Company has been authorized to conduct a professional liability insurance study for the MSMA.

At a June 8 meeting the Committee on Professional Liability Insurance voted unanimously to accept the company's study proposal. The study results, which are not binding on the MSMA, are expected to be reported to the Association by early Fall.

Included in the study will be:

(1) Examination of choices of insurance carriers
(2) Investigation of other Association-connected professional liability plans
(3) Drawing up a design for actual language relating to eligibility, coverage, rate structure
(4) Securing legal opinions regarding various aspects of setting up a statewide plan
(5) Determining methods for merchandising the plan to Association members.

News-in-Brief

HCFM gets PSRO grant

The Health Care Foundation of Missouri has been awarded a 6-month grant to establish a Statewide Professional Standards Review Support Center.

The grant of $106,686 was announced June 23 following approval of the Foundation's proposal by the U.S. Department of Health, Education and Welfare.

Currently called HCFM/PSRO Support Center, the Foundation will move into expanded offices at 1907 Williams Street in Jefferson City around July 15.

John W. Noble dies

John W. Noble, who for many years served as General Counsel and Parliamentarian for the Missouri State Medical Association, died June 8 at his home in Kennett.

Mr. Noble, 70, had served in the Missouri Senate for 16 years.

Members offered new plans

MSMA members recently received information concerning a new Office Overhead Expense Disability Insurance plan which was approved by the 116th House of Delegates.

Many members had requested that the disability plan be added to the MSMA package since the Association's group purchasing power results in superior benefits at more favorable costs than individual contracts.

The plan is administered by Eggert-Carroll-Schroeder Agency, Inc. of St. Louis, and Altman-Singleton and Company of Kansas City. The Commercial Insurance Company is the insuror.

A second new insurance plan, a $100,000 Major Medical program, will be mailed to members during July.

The Major Medical plan pays up to $100,000 in benefits for each and every condition, for each and every person covered. This plan replaces the old hospital insurance offered by the MSMA. Those members currently insured under the old plan have two choices. They can keep their present policy or they can transfer to the new Major Medical plan without proving insurability if the transfer is made within 30 days after the new plan is formally offered.

The Major Medical plan is administered by Forrest T. Jones and Company of Kansas City. Phoenix Mutual is the insuror.

A new MSMA $100,000 Term Life Insurance plan will be available to members in the Fall.

For further information on any of these plans, contact the plan administrator or MSMA Headquarters.

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Supplied: **Tablets:** 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded in bottles of 100, 500, and 1000.

Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent.

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendi of the type I envisio would fill a definite need for the pract ing physician. Suc compendium wo give him all t information ne essary for usi a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactio with other drugs.

The information would be based on the package insert and have the same legal status. In fa a complete compendium with co plete and current information might even eliminate the necess

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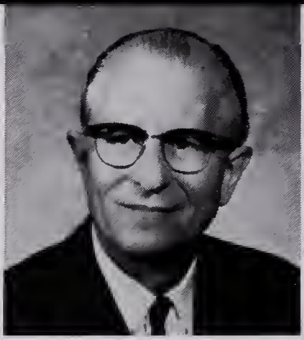
Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, i sponsorship. They should contai comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every ye

Function of a Compendium

A compendium should furnish the following information o drugs in the following order: indi tions for use, side effects, adver drug reactions, contraindication drug interactions, drug dosage a the dosage forms marketed. Dru prices should not be included be cause they vary so widely and change rapidly.

No compendium should se forth drugs of choice or discuss relative efficacy. Such question must be left for the practicing pl sician to decide, whether on the basis of the medical literature, h own clinical experience, advice colleagues, information supplie by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor how to use drugs. Rather, it mus be a reference source designed marily to refresh his memory as drugs he may not use regularly.

a package insert in many in-
nces. This would constitute a
stantial saving for the manu-
turer.

By a complete compendium,
not mean a volume of prohibi-
size. You don't need a book
cribing 25,000 products with
enormous amount of repetition.
her, drugs should be arranged
class. Mutually applicable infor-
tion would be provided, along
brief discussions pinpointing
erences in specific drugs of
t class. Listings would be cross-
exed in a useful way.

er Available Documents as rces of Information

Existing references such as
R and the AMA Drug Evaluation
obviously useful but they are
omplete. Either they are not
ss-referenced by generic name
do not group drugs with simi-
characteristics, or they do not
all the available and legally
rketed drugs. And some of
se omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

uld in no way imply control over
practitioner's prerogatives.

y Another Compendium?

A practicable, single-volume
npendium cannot, nor is it
essary to, include all drugs on
market today. From my prac-
of internal medicine for some
years, my experience as a con-
tant, and as a faculty member
our or five medical schools, I
uld estimate that a doctor uses
y 30 to 35 drugs regularly. The
72 Physicians' Desk Reference,
identally, contained about
00 entries.

As to whether there should be
ederal compendium, in my opin-
, as stated earlier, the answer is
y—there should *not* be one. The
posal assumes that existing
npendia are inadequate. We're
sure of that at all. Whatever its
perfections, the present drug
ormation system in the U.S. is
n, multifaceted, pluralistic and
ensive. Good compendia exist,
well as other ample sources on
g therapy, ranging from journal
rature through AMA Drug Evalu-
on to company materials. Not
physicians may use such
rces as often or as well as they
uld, but that is the fault of the
n, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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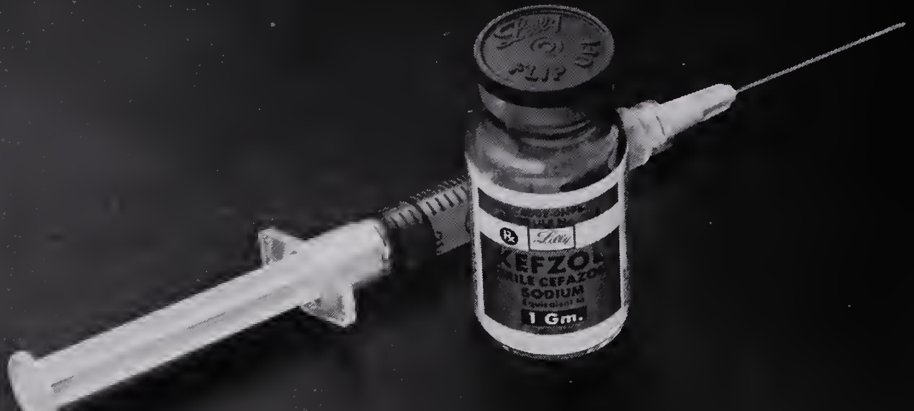

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Additional information available to the profession on request.
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Indianapolis, Indiana 46206
400380

Volume 71, Number 7—July, 1974

Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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> *". . . our unity is what will be required to withstand the many outside pressures facing us today and allow the physicians of our state and nation to practice the best form of medicine in the world."*

Remarks of G. A. Stricker, M.D., President

E. A. Stricker, M.D.

Mr. Speaker, Officers, Members of the House of Delegates:

Much of my term as President of the Missouri State Medical Association has been focused on state activity in regard to matters of national interest.

PSRO, hospital preadmission certification, wage-price controls and national health insurance are the primary problems which physicians have faced during the past year. I can assure you, your State Association has been active on all these fronts.

Through letters, telegrams and face-to-face discussions, your Association leaders have informed Missouri's congressmen and senators of Medicine's concern in these areas of vital importance not only to us doctors, but equally to our patients.

The opinions of your Association officers and the opinions of many, many of your fellow MSMA members will be brought before this House for deliberation during the next four days. You, as Delegates representing the physicians from your local areas, will decide what directions this Association will take on these issues in the future. Perhaps we shall continue the present course or, perhaps by your actions, we shall change directions.

That, of course, is the way it *should* be. This Association was originally chartered on the concept that it would represent its members, and that concept has not and should not be changed.

That is where our strength lies. When physicians, who are often noted for their individuality and self-reliance, can unite behind common goals for the betterment of medicine, our entire state and nation benefit. So, study carefully the many issues before you at this Annual Session. Your decisions will guide the official actions of our 4,500-member Association in the future.

I don't believe an outgoing President should present a completely solemn "State of the Association" address if there are assets on the other side of the ledger.

The past year, I am convinced, had its share of plusses.

Membership in the MSMA again showed a gain over the previous year. Our growth has been steady and in proportion to the number of physicians practicing in Missouri. We now have approximately 4,500 members. Also, membership of Missouri physicians in the AMA has risen for the first time in the past few years. In fact, the MSMA was recognized with an award by the AMA for its mem-

(Continued on page 318)

James C. Cope, M.D.

"Our first concern this year has been to stimulate legislative awareness and to stress the importance that priority medical legislative awareness and action should have in our lives."

Remarks of James C. Cope, M.D., President-Elect

Fellow Physicians:

The year just past has been and, I hope will remain unique in the history of our country and our profession. We have been subjected to hundreds of hours of news comments about a stupid break-in during which one of our experienced Secret Service agents was apprehended by a night watchman. A Vice-President, for whom many of us like myself had a deep admiration, has had to resign because of income tax evasion, and, we suspect, greater wrongdoing was covered up by plea bargaining. The economy is out of control, the stock market has gone crazy. Any serious attempt to control inflation is in shambles. Prices are going up and, at the same time, profits are going down. Dividends are becoming nonexistent. The fuel crunch, which seemed to arrive suddenly and unannounced, threatens our way of life and our future. We find editorials in the news columns, propaganda on the editorial page and cold fact hard to come by.

The situation in our profession is no better. The Ex-Chairman of the Board of Trustees of the American Medical Association is serving time in a federal prison for misuse of bank funds. This, incidentally, was the violation of a federal regulation and not a crime, since there were no victims and no loss of money by anyone. Too bad he didn't have Agnew's lawyer.

The movement toward unionism has sprouted and taken root. The AMA has had to threaten to take the Secretary of HEW to court to make him listen to the only source of medical care in the United States of America. State societies are in danger of being fragmented by an arbitrary designation of PSRO areas.

Hospital preadmission certification by a committee other than the doctor clearly states that the Department of HEW thinks physicians are too stupid to know when a patient needs to be hospitalized or so dishonest that we would order unnecessary hospitalization for his own gain.

In spite of a runaway inflation, our fees have been fixed by the Cost of Living Council that now exists only to control physicians' fees and hospital costs.

Even in the area of medical practice, tensions are building in severity and at an ever-increasing rate.

If we consider 62 years to be a generation, then there have been 39 such generations since Hippocrates, the Father of Medicine. The circulation of the blood was discovered in the 34th generation, the microscope in the 36th, vaccination against smallpox in the 37th, the germ theory of disease and X-ray in the 38th and everything else in the 39th, the generation we are living in now.

With these remarks as prologue, it becomes obvious that the practicing physician is caught in a runaway whirlwind over which he has little control, but for which he is still held responsible. Should the physician fall behind in the progress of medicine, he will be sternly viewed by the PSRO and subject to malpractice suits. Unknowing violation of federal regulations can result in severe penalties. This is what happened to Dr. Kernodle. (Any physician in this room who does not have his fee schedule posted or at least available may be subject to a fine of $5,000.)

Reaction to these pressures can take several forms. A feeling of frustration may cause the physician, or a group of physicians, to lash out at some inappropriate and usually undeserving target. The reaction may take the form of withdrawal in an attempt to maintain the illusion of no change at all. A common reaction is simply one of apathy and defeatism. All such reactions are self-destructive. The only hope of weathering the storm is to keep a firm control of our profession and ourselves by reacting promptly and appropriately to each new stimulus.

Appropriate reaction demands knowledge and analysis to each new development. To expect each busy physician to keep abreast of such developments is expecting the impossible. But the demand for the impossible is still being made, and failure to meet such demand is fraught with danger. It seems, therefore, that our course is clear. We must develop a knowledgeable staff who will predigest, and spoon-feed us with the knowledge we must have for our existence. Those of you in this room, a little less than 200 physicians, represent only 5% of the physicians of Missouri; another 10% may attend the meeting. It is imperative that the MSMA establish communication with the other 85% of its membership if they, or it, are to survive as entities. In the crush of medical events which are quickly leading toward universal, government-regulated, comprehensive health insurance when every patient is subject to review, certification and inquiry, there can be no medical dropouts.

To accomplish this end, this House of Delegates is being presented with a program of action that will, if implemented, have a far-reaching beneficial effect on the society and on the practice of medicine in Missouri.

The program consists of three major thrusts: Education, Communication and Service.

Of these, Education is probably the most important. Already several states have laws making it mandatory for the physicians to have a certain number of hours of graduate education each year for relicensure. We may rest assured that along with review and certification, continuing education will be one of the requirements for participation in government programs. As the requirement of continuing education grows, so does the responsibility of the medical society to make such education available to its members.

In this area, your Ad Hoc Committee on Continuing Medical Education, which is so ably headed by Dr. Paul R. Young, has plans that are well advanced. Whether these plans come to fruition is dependent upon your actions at this meeting. In addition to medical education, instruction in a growing and complicated mass of government regulations also is necessary. In the future, I see a need for careful attention in this area. With the advent of PSRO and National Health Insurance, each physician will become deeply involved. Leadership, Education and Political Education are of lesser but still great import.

In the past eight years in which I have served on the Council, I have learned two things about communication. The first is that physicians throw most of their mail away, unread; and second, that eyeball-to-eyeball confrontation is the only sure way of communication.

To make the eyeball-to-eyeball approach work, it is proposed that we return to the established technique of having Field Secretaries who, hopefully, will see every physician in the state at least every six months at either scheduled meetings in the hospital or in the physician's office. These Field Secretaries will carry out most of the burden of keeping the membership informed of what is going on in government at state and national levels. It also will be an important part of their duty to provide a pipeline from the local level to the State Association. In addition to the Field Secretaries, it is proposed that the Councilors have a moderate budget. It was my experience that a letter on my personal letterhead would almost invariably be read, while a form letter from the State Association would frequently hit the round file before the doctor had an opportunity to read it.

A special attempt will be made to contact and interest the members of the Association who never attend their County Society meetings and who are totally uninformed about the benefits and aims of organized medicine.

Finally, we come to the area of service.

When Benjamin Franklin conceived the idea of mutual insurance, he remarked that by forming such a mutual group, each person could help the other and, at the same time, not do a disservice to himself. That is our plan. In the future, we see no relief from the ever-increasing requirements for funds to run the Missouri State Medical Association. If we depend totally on dues, there will be the often repeated request for more money. The AMA generates about half of its income from sources other than dues. I believe that the MSMA can do the same. Our preliminary investigations indicate that such is the case.

You will, at this session of the House, have an opportunity to decide whether the MSMA will develop its own professional liability program. Other states have done this with a great saving to its members and a nice income to the Association.

Automobile insurance, if bought by a group such as the MSMA, can be had at about a 20% discount.

The travel tours which the MSMA sponsors could result in appreciable income, if the program were to be expanded.

Car rentals, with option to buy, is another area in which the group can both make money for the group and save for the individual.

As this service program develops, should you see fit to move into this area, I believe that the Field Secretaries can and will act as salesmen and service representatives.

This, then, is the outline of the program upon which you will decide. As in any project or endeavor, funds will be needed to get it off the ground. The Planning Committee has suggested a $25 increase in dues for 1975. We believe this amount will let us move ahead and, above all, let us develop a service program that will be a great help with the future financing of the MSMA. The special assessment of $10 for the Missouri State Medical Foundation should be continued.

I cannot leave the subject of dues without pointing out that the dues of the MSMA are in the lowest 25th percentile of the nation; only three states, and Puerto Rico have dues less that $75. This projected raise would bring it to the 50th percentile.

Your Planning Committee, your Council and your Commissions have approved this program. It is the opinion of your President-Elect that it is not only desirable, but almost imperative that it be implemented.

In adopting this program, the State Association takes on great responsibility.

We assume the responsibility for a program of continuing medical education that we believe will be mandatory within a few years.

We assume the responsibility of digesting and keeping the membership informed of changing government regulations concerning the practice of medicine.

We assume the responsibility of trying to communicate with the members of the Association who, to date, have shown little desire to be communicated with.

We assume the responsibility of developing a service organization that will benefit each member of the Association to the degree he wishes to use it.

The resolutions necessary to accomplish these things will soon be introduced. They will, of course, be debated before your Reference Committees. We would be more than naive should we expect no diverse opinion. If, however, this Society is to move ahead and become an even greater influence in Missouri medicine, your approval of this plan is necessary.

To quote Justice Holmes, "I find a great thing in this world is not so much where we stand, as in what direction we are moving. We must sail sometimes with the wind, sometimes against it, but we must sail and not drift nor lie at anchor."

"The only hope of weathering the storm is to keep a firm control of our profession and ourselves by reacting promptly and appropriately to each new stimulus."

Mrs. Charles R. Willman

Report of
Mrs. Charles R. Willman
President of the Woman's Auxiliary

Mr. Speaker, Dr. Stricker, Members of the House of Delegates and Guests:

I am pleased to be able to come before this assembly and report on the year which marks the end of 50 years of Auxiliary work for doctors' wives. Fifty years ago, a small group of physicians' wives with vision and courage founded the Woman's Auxiliary to the Missouri State Medical Association. Mrs. Willard Bartlett from St. Louis was the organizer. In July, 1924, she wrote in the *Journal of the Missouri State Medical Association,* and I quote, "Our immediate aim is to educate ourselves in matters of public health and to be prepared to secure the backing of women's organizations and other groups for legislative enactments which the Missouri State Medical Association desires to be passed." End quote.

This is still one of the aims of our organization today.

To commemorate our Golden Anniversary, several of the Past-Presidents have written a very interesting book about the 50 years of the Auxiliary entitled "50 Years of Service." This will be for sale during the Convention at the registration desk. We are honoring all the Past-Presidents of the Auxiliary at the luncheon Saturday noon during this Convention.

In order to outline areas of concern, I initiated the five-point Tel-Star program this year. They are Tel-e-Member, Tel-e-Youth, Tel-e-Leg, Tel-e-Program and Tel-e-Community.

First, Tel-e-Member. In an official survey of physicians, it was revealed that communications and public relations are among their top priorities. Just imagine what an important public relations job we could do if every eligible physician's wife joined our ranks.

We have a membership of 1,610, which is far less than it should be. We do not have as many organized counties now as we did a few years ago. We urge every physician's wife to become a member. This means help from all of you. I believe we can help you by telling your wife of the importance of supporting the MSMA and the Auxiliary, but the time has come when we must work together more. There is a wealth of knowledge, enthusiasm and know-how among the Auxiliary members, which has never been tapped. Unity will be the name of the game in the coming year as we put it all together for good health. Some Auxiliaries are accomplishing this by having auxiliary members serve on the society membership committee and by working together in a community service program, such as Immunization. During the past year, I appointed a Board Member to serve on the MSMA Committee of Health Manpower, Missouri Loan Foundation (MSMF), Legislation and Public Affairs to help coordinate the work of both groups.

Another point many Auxiliaries stressed was Tel-e-Legs ("Legs" stand for Legislative Effort Group System). Our first concern this year has been to stimulate legislative awareness and to stress the importance that priority medical legislative awareness and action should have in our lives. We have encouraged members to join MMPAC and become interested in Public Affairs. Special emphasis has been given to the LEGS line as a form of communication with all our members concerning current legislation that needs our attention. It has been very effective. Legislation Day was held in Jefferson City last April, when women came from all over the state to attend sessions of the Senate and House of Representatives.

Under the point of Tel-e-Youth, many Auxiliaries have had fund-raising benefits which have been used for scholarships and loans to deserving students. Also, all county auxiliaries have contributed in some way to raising money for the American Medical Education Research Foundation—a total of $15,113.26 for this year.

We also are very proud that many county auxiliaries have raised money for the Missouri State Medical Foundation. This year, we contributed $1,541.

Tel-e-Community is the fourth point of the Tel-Star Program. All county auxiliaries do Community Service, whether it be in helping staff clinics and Bloodmobiles or in helping to entertain the elderly in nursing homes. The Meals-on-Wheels Program and giving parties for handicapped children were done. Also, some gave financial aid to centers for the Rehabilitation of Youth Addicted to Drugs.

The last point is Tel-e-Program. We have stressed using the package programs supplied by the National Office as a tool not only for the Auxiliary, but to be used by our members in other organizations to which they belong. Some of these programs which have been used this year are on Drug Abuse, Alcoholism, Gems—the baby sitting course, Public Affairs, Nutrition, Immunization and Mental Health. Also, Environmental Health programs were stressed. We held an Environmental Symposium in Kansas City in September. Members from all over the state came to hear specialists from the Environmental Protection Agency. We visited the River Quay area downtown, where old buildings have been "recycled" into an attractive shopping and entertainment area.

On behalf of the Auxiliary members, I wish to express our thanks and appreciation for your concern and support of our many projects. I want to extend personal thanks to Dr. Stricker; the Advisory Council—Dr. Martin, Dr. Gunn and Dr. Chandler; and to Mr. Ray McIntyre and his staff. They have given me much support. And now, we wish for you a very good Convention.

Remarks of the President

(Continued from page 313)

bership gains. Nearly 3,700 Missouri physicians are AMA members.

We have been very fortunate on the state legislative scene. In the General Assembly, which ended last June, six bills supported by your Association passed the Legislature and have been signed into law. Perhaps far more important is the fact that of the six bills opposed by the MSMA, none were passed.

Similarly, it appears as if medicine will again do well in the present session of the Missouri Legislature. As anyone who had dealt in the political ring is well aware, of course, that it is impossible to predict the outcome until final adjournment.

Another important area which has experienced added incentive during the past year has been MMPAC, our Political Action Committee. The Board of Directors has been expanded and the Rules and Regulations updated in an effort to be more responsive to its members and to Medicine in Missouri. I think that the more you look into MMPAC, the more convinced you will become that it is a vital and necessary companion of our Association.

Finally, we have continued a program of attempting to improve communications within our Association. This has been a slow task due largely to lack of adequate funds and staff. Yet, this is an area which must be seriously considered if the Association is to keep its members informed on the many issues I mentioned previously.

You can see, therefore, that although the past year has been one of turmoil on many issues of national importance, your Missouri State Medical Association has taken an active role in these issues and has experienced gains in other areas which serve to unify the physicians of our state.

After all, our unity is what will be required to withstand the many outside pressures facing us today and allow the physicians of our state and nation to practice the best form of medicine in the world.

The patient with asthma or allergy:
another type for Tylenol®
(acetaminophen)

When the allergic patient has a condition requiring an analgesic, a new problem arises. "Idiosyncrasy to salicylates is not rare and is usually manifested by skin rashes and anaphylactoid reaction. Sensitivity to these drugs occurs more frequently in patients with asthma and allergy."[1] Moreover, the previous ingestion of aspirin without ill effects is no guarantee that subsequent use will not precipitate a severe reaction.[2]

TYLENOL (acetaminophen), on the other hand, presents little risk of allergic reaction, even in patients sensitive to aspirin,[3] making it the preferred analgesic for the allergic patient.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L.: Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961: abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin,
yet just as effective for relief
of pain and fever

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(acetaminophen)

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Minutes of the
116th Annual Session

MISSOURI STATE MEDICAL ASSOCIATION

House of Delegates
Crown Center Hotel, Kansas City
April 4-7, 1974

FIRST SESSION

The First Session of the House was called to order at 1:30 PM on April 4, 1974 in the Century Room with R. A. Slickman, Speaker, presiding. The following officers, councilors and delegates were present during the 116th Annual Session:

Officers

President	E. A. Stricker, St. James
President-Elect	James C. Cope, Columbia
Vice-President	R. Lee Cooper, Warrensburg
Vice-President	Rae W. Froelich, Lebanon
Vice-President	Robert W. Kelley, St. Louis
Secretary	John I. Matthews, Jefferson City
Treasurer	Donald R. Judd, St. Louis
Speaker of the House	Robert A. Slickman, Kansas City
Vice-Speaker of the House	James T. Brown, Springfield
Immediate Past-President	Walter T. Gunn, St. Louis

Councilors

1st District	John N. Martin, St. Joseph
2nd District	Lysle M. Bach, Hannibal
3rd District	Max S. Franklin, St. Louis
4th District	Louis P. Hetlage, Troy
5th District	Robert E. Bregant, Jefferson City
6th District	William D. Bradshaw, Clinton
7th District	R. Allen Chandler, Kansas City
8th District	Howard J. McAlhany, Springfield
9th District	Claude W. Cooper, Thayer
10th District	Eugene T. Hansbrough, Poplar Bluff

DELEGATES

First District

Buchanan	Allen I. Herman, St. Joseph
Buchanan	William B. Rost, St. Joseph
Buchanan	Ernest E. Wadlow, St. Joseph
Clay	Chris K. Fotopoulos, North Kansas City
Clay	Donald E. Kuenzi, Kansas City
Clay	William R. McPhee, Kansas City
Clinton	Larry A. Ozenberger, Plattsburg
Grand River	Watkins A. Broyles, Bethany
Grand River	Albert D. Cross, Trenton
Grand River	John R. Dixon, Brookfield
Grand River	George Mandler, Chillicothe
Northwest	Robert E. Dunshee, Maryville
Northwest	E. D. Imes, Maryville
Northwest	Frank B. Matteson, Grant City
Northwest	Troy O. Morgan, Jr., Albany

Second District

Chariton-Macon-Monroe-Randolph	J. E. Campbell, Macon
Chariton-Macon-Monroe-Randolph	C. C. Cohrs, Moberly
Chariton-Macon-Monroe-Randolph	D. D. Stuart, Brunswick
Lewis-Clark-Scotland	Landis Y. Davis, Canton
Marion-Ralls-Shelby	Phillip B. Foreman, Hannibal
Marion-Ralls-Shelby	Stanley Hall, Hannibal
Marion-Ralls-Shelby	Edward M. Plowman, Hannibal
Pike	Charles H. Lewellen, Louisiana

Third District

St. Louis City	Luis B. Anglo, St. Louis
St. Louis City	Ralph L. Biddy, St. Louis
St. Louis City	George Bohigian, St. Louis
St. Louis City	Richard V. Bradley, St. Louis
St. Louis City	George Brennan, St. Louis
St. Louis City	Robert Brookes, St. Louis
St. Louis City	Thomas J. Cooper, St. Louis
St. Louis City	Robert C. Drews, St. Louis
St. Louis City	Richard H. Fallon, St. Louis
St. Louis City	Daniel M. Fraser, St. Louis
St. Louis City	Paul L. Friedman, St. Louis
St. Louis City	August W. Geise, St. Louis
St. Louis City	George Hawkins, St. Louis
St. Louis City	James N. Heins, St. Louis
St. Louis City	Patrick C. Hogan, St. Louis
St. Louis City	Charles A. Jost, St. Louis
St. Louis City	Donald R. Judd, St. Louis
St. Louis City	John Kellett, St. Louis
St. Louis City	Robert W. Kelley, St. Louis
St. Louis City	John J. Kelly, St. Louis
St. Louis City	Lawrence Lawton, St. Louis
St. Louis City	Francis X. Lieb, St. Louis
St. Louis City	J. Otto Lottes, St. Louis
St. Louis City	Philip Luedde, St. Louis
St. Louis City	William C. MacDonald, St. Louis
St. Louis City	Paul F. Max, St. Louis
St. Louis City	Robert N. Miller, St. Louis
St. Louis City	Michael G. Murphy, St. Louis
St. Louis City	Frank J. Niesen, St. Louis
St. Louis City	Lawrence W. O'Neal, St. Louis
St. Louis City	Theodore L. Paletta, St. Louis
St. Louis City	Harry A. Reich, St. Louis
St. Louis City	Hubert A. Ritter, St. Louis
St. Louis City	Charles S. Sherwin, St. Louis
St. Louis City	James M. Stokes, St. Louis
St. Louis City	Clarence M. Turner, St. Louis
St. Louis City	Joseph B. Vacca, St. Louis

St. Louis City	Leo L. Wacker, St. Louis
St. Louis City	Carol F. Williams, St. Louis
St. Louis City	George Zografakis, St. Louis

Fourth District

Franklin-Gasconade-Warren	Harold Hoelscher, Warrenton
Franklin-Gasconade-Warren	William R. Richardson, Union
Franklin-Gasconade-Warren	George Workman, Hermann
Jefferson	Vicente D. Deles, Crystal City
St. Charles-Lincoln	Edward Damron, Elsberry
St. Charles-Lincoln	James P. Felder, St. Charles
St. Charles-Lincoln	Paul H. Rother, St. Charles
St. Louis County	Vernon H. Balster, St. Louis
St. Louis County	C. Read Boles, St. Louis
St. Louis County	Edwin J. Cunningham, St. Louis
St. Louis County	Edgar Davis, St. Louis
St. Louis County	Robert B. Deitchman, St. Louis
St. Louis County	Jack R. Eidelman, St. Louis
St. Louis County	Allen P. Klippel, St. Louis
St. Louis County	Jules H. Kopp, St. Louis
St. Louis County	John M. Laird, St. Louis
St. Louis County	Robert A. Mayer, St. Louis
St. Louis County	Jerry Middleton, St. Louis
St. Louis County	Frederick D. Peterson, St. Louis
St. Louis County	Rudy Ruhling, St. Louis
St. Louis County	Melvin Schwartz, St. Louis
St. Louis County	James Sisk, St. Louis
St. Louis County	Miles C. Whitener, St. Louis

Fifth District

Audrain	Benjamin N. Jolly, Mexico
Boone	William C. Allen, Columbia
Boone	Kenneth K. Keown, Columbia
Boone	John T. Logue, Columbia
Boone	Benedict A. Moranville, Columbia
Boone	William B. See, Columbia
Boone	Hugh E. Stephenson, Jr., Columbia
Cole	Henry V. Guhleman, Jr., Jefferson City
Cole	Thomas J. Ryan, Jefferson City
Cole	Jack S. Sanders, Jefferson City
Cooper	George W. Winn, Boonville
Morgan	C. Robert Hall, Versailles

Sixth District

Henry	Richard H. King, Clinton
Lafayette-Ray	William C. LaHue, Lexington
Lafayette-Ray	Charles T. Riley, Richmond
Pettis	J. E. Block, Sedalia
Saline	James A. Reid, Marshall
West Central	Alfred W. Eklund, Pleasant Hill
West Central	Arthur L. Hansen, Butler
West Central	Robert L. Magee, El Dorado Springs
West Central	R. John Torontow, Nevada

Seventh District

Jackson	Alfred D. Biggs, Jr., Kansas City
Jackson	T. J. Bryant, Kansas City
Jackson	Calvin E. Englemann, Kansas City
Jackson	Robert C. Fairchild, Shawnee Mission, Kan.
Jackson	Robert W. Forsythe, Kansas City
Jackson	Fred D. Fowler, Kansas City
Jackson	Thomas J. Fritzlen, Kansas City
Jackson	Braham J. Geha, Kansas City
Jackson	John A. Griffith, Jr., Kansas City
Jackson	Edward E. Haith, Kansas City
Jackson	William D. Hoadley, Kansas City
Jackson	Burnell Landers, Kansas City
Jackson	Vance E. Link, Independence
Jackson	R. Stacy Long, Kansas City
Jackson	George J. Lytton, Kansas City
Jackson	Andrew McCanse, Kansas City
Jackson	Edwin E. MacGee, Kansas City
Jackson	Richardson K. Noback, Kansas City
Jackson	Mark D. Ost, Kansas City
Jackson	Milton B. Ozar, Kansas City
Jackson	Sidney F. Pakula, Kansas City
Jackson	Gordon A. Sauer, Kansas City
Jackson	John M. Singleton, III, Kansas City
Jackson	Robert A. Slickman, Kansas City
Jackson	W. Jack Stelmach, Kansas City
Jackson	C. Y. Thomas, Jr., Kansas City
Jackson	Herbert J. Waxman, Kansas City
Jackson	George P. Williams, Kansas City

Eighth District

Barton	Thomas W. Carroll, Lamar
Dallas-Hickory-Polk-Dade	Evelyn Griffin, Buffalo
Dallas-Hickory-Polk-Dade	O. A. Griffin, Buffalo
Dallas-Hickory-Polk-Dade	Lee A. McNeel, Jr., Greenfield
Greene	James T. Brown, Springfield
Greene	Walter A. German, Springfield
Greene	Noel R. Lewis, Springfield
Greene	Stanley S. Peterson, Springfield
Greene	Bruce I. Shackter, Springfield
Greene	Thomas P. Sweeney, Springfield
Greene	William M. Walker, Springfield
Jasper	John R. Esther, Joplin
Jasper	F. Wendell Pence, Carthage
Jasper	Marvin A. Singleton, Joplin
Ozarks	Paul B. Anderson, Neosho
Ozarks	Charles S. Christianson, Mt. Vernon
Ozarks	Sergio G. Cruz, Jr., Monett
Ozarks	Kenneth Glover, Mt. Vernon
Ozarks	Arthur Graves, Mt. Vernon
Ozarks	Roy E. Kenney, Neosho
Ozarks	Stanley D. Roper, Ozark
Ozarks	Fred Wommack, Crane
Webster	T. M. Macdonnell, Marshfield

Ninth District

Mid-Missouri	B. J. Bass, Salem
Mid-Missouri	Frank A. Elders, Cuba
Mid-Missouri	Earl E. Feind, Rolla
Mid-Missouri	Rae W. Froelich, Lebanon
Mid-Missouri	Barbara E. Russell, Rolla
South Central	James A. Hasek, Mountain Grove
South Central	C. Franklin Smith, Willow Springs
South Central	Joe A. Wall, Houston
South Central	Jack N. Wiles, West Plains

Tenth District

Butler-Wayne-Ripley	Fred Caldwell, Poplar Bluff
Butler-Wayne-Ripley	George H. Ladyman, Poplar Bluff
Butler-Wayne-Ripley	T. Eugene Ruff, Poplar Bluff
Cape Girardeau	Charles H. Cozean, Jr., Cape Girardeau
Cape Girardeau	Melvin C. Kasten, Cape Girardeau
Cape Girardeau	Harold B. Rapp, Cape Girardeau
Dunklin	George Dunmire, Kennett
Mineral Area	Metin Arat, Farmington
Mineral Area	C. W. Chastain, Farmington
Mineral Area	Robert Dettmer, Ironton
Mineral Area	Norma Farmer, Farmington
Mineral Area	A. G. Karraker, Farmington
Mineral Area	A. R. Rao, Fredericktown
SEMO	Max A. Heeb, Sikeston

SEMO Ronald T. Hill, Dexter
SEMO ...... Gregorio L. Rodriguez, Charleston

PAST-PRESIDENTS—DELEGATES-AT-LARGE

Hector W. Benoit, Jr., Kansas City
Victor Buhler, Kansas City
Joseph L. Fisher, St. Joseph
Walter T. Gunn, St. Louis
Kenneth C. Hollweg, Kansas City
David N. Kerr, St. Louis
James R. McVay, Kansas City
Doyle C. McCraw, Bolivar
Guy N. Magness, University City
Gerald L. Miller, Kansas City
Robert Mueller, St. Louis
Byron M. Stuart, Boonville
Paul R. Whitener, St. Louis

STUDENT DELEGATES

Mr. John Brandt, University of Missouri-Columbia School of Medicine
Mr. Ed Maloney, University of Missouri-Columbia School of Medicine
Mr. Merlin Brown, University of Missouri-Kansas City School of Medicine
Ms. Patricia Hubbell, University of Missouri-Kansas City School of Medicine
Mr. John P. Jones, St. Louis University School of Medicine
Mr. Ira M. Rutkow, St. Louis University School of Medicine
Mr. Frank R. Brown, III, Washington University School of Medicine
Mr. R. Lynn Horne, Washington University School of Medicine

The invocation was given by Association President E. A. Stricker.

The Speaker introduced Mrs. Herbert L. Mantz of Kansas City as Parliamentarian for the House of Delegates. Mrs. Mantz is a Past-President of the National Association of Parliamentarians and has been Parliamentarian for the Woman's Auxiliary to the American Medical Association for many years.

Dr. George J. Lytton, Chairman of the Credentials Committee, reported that satisfactory credentials had been presented by nine officers, ten councilors and 151 delegates. He informed the House that this number of delegates constitutes a quorum and dispensed with a roll call.

Dr. R. Allen Chandler, Chairman of the Committee on Arrangements, welcomed the Association members, their wives and guests to the 116th Annual Session and expressed hope for a successful meeting.

The minutes of the 115th (1973) Annual Session, which were published in the July 1, 1973 issue of Missouri Medicine, were approved as published.

The Speaker announced appointment of the following reference committees and presented his instructions to the committees:

ON AMENDMENTS TO THE CONSTITUTION AND BYLAWS

R. Stacy Long, Kansas City, Chairman
Richard H. Fallon, St. Louis
Chris K. Fotopoulos, N. Kansas City
Phillip B. Foreman, Hannibal
Bruce I. Shackter, Springfield

ON MEDICAL EDUCATION AND PUBLIC WELFARE

James M. Stokes, St. Louis, Chairman
Richardson K. Noback, Kansas City
Vicente D. Deles, Crystal City
Norma D. Farmer, Farmington
Marvin A. Singleton, Joplin

ON MISCELLANEOUS AFFAIRS

Benedict A. Moranville, Columbia, Chairman
Paul L. Friedman, St. Louis
Thomas J. Fritzlen, Kansas City
E. J. Cunningham, Jr., St. Louis Co.
Charles T. Riley, Richmond

ON NECROLOGY

Fred Caldwell, Poplar Bluff, Chairman
George W. Winn, Boonville
Robert E. Dunshee, Maryville
Thomas P. Sweeney, Springfield

ON REPORTS OF OFFICERS

Paul H. Rother, St. Charles, Chairman
Lawrence W. O'Neal, St. Louis
Noel R. Lewis, Springfield
Albert D. Cross, Trenton
Jack S. Sanders, Jefferson City

ON RESOLUTIONS

Harold B. Rapp, Cape Girardeau, Chairman
A. W. Geise, Jr., St. Louis
C. Y. Thomas, Kansas City
Robert B. Deitchman, St. Louis Co.
James A. Hasek, Mountain Grove

The Speaker introduced Dr. Stricker who delivered the annual President's Message.

(The President's Message is published on page 313.)

The Speaker then asked Dr. James C. Cope to present the annual message of the incoming President.

(Dr. Cope's address is published on page 314.)

(Both Presidential messages were referred to the Reference Committee on Reports of Officers.)

The Speaker then invited Mrs. Charles R. Willman to present the annual report of the President of the Woman's Auxiliary.

(This report is published on page 317.)

(Mrs. Willman's report was referred to the Reference Committee on Reports of Officers.)

The Speaker introduced Mrs. George J. Lytton, President-Elect of the Woman's Auxiliary to the MSMA.

The Speaker stated that the reports of the Health Care Foundation of Missouri, Officers, Committees, Commissions and Council were published in the Delegates Handbook and referred the reports to the appropriate reference committees. He asked for any supplementary reports from committee and commission chairmen. There were no supplementary reports.

The Speaker then requested any supplementary report of the Council. He referred the various subjects within the Supplementary Report of the Council to appropriate reference committees.

(This report is published on page 372.)

The reports of the Health Care Foundation of Missouri, Officers, Committees, Commissions and Council are as follows:

REPORT OF THE HEALTH CARE FOUNDATION OF MISSOURI

Nineteen hundred seventy-three was a year of regrouping and reappraisal for the Health Care Foundation of Missouri.

In January, 1973, the Health Care Foundation of Missouri and the officers of the Missouri State Medical Association were exonerated in the lawsuit brought against them by ten individual physicians from the St. Louis area. An appeal was sought by the plaintiffs, but in the pre-appeal review, the

Health Care Foundation of Missouri was deemed not to be an appropriate defendant and is no longer a party to the lawsuit, from what our legal counsel has advised us.

The passage of Public Law 92-603, better known as HR-1 with its PSRO sections, in late 1972 indicated some needs for operational and long-range planning on the part of the Health Care Foundation's activities. In early January, 1973, the Bylaws were subjected to a significant revision with several goals in mind. First, there was an attempt to restructure the electoral process to render selection of all levels of participants in the activities of the Foundation as totally democratic as possible. Secondly, it was hoped to provide more autonomy and operational independence in each of the five panel review areas, anticipating the probability that Missouri would be allotted several geographic areas by the Department of HEW in the establishment of PSROs. Third, it was felt that the role of the consumer needed better identification in order to have appropriate counsel and outside expertise available to the management and operation of the physician-controlled peer review process. These proposed revisions in the Bylaws were presented to the Administrative Members of both the MSMA and the MAOPS and were passed. Implementation was, however, delayed because of further developments to be mentioned later on in this report. After considerable study, the Bylaws were returned to both the Administrative Members of MSMA and MAOPS with the request by the Board of the Health Care Foundation that their action approving these Bylaws be rescinded, with the intention that further advice and counsel would be needed before the new revisions could be brought back to the organizations for their final approval. At the present time, a special committee of the Board including both M.D.s and D.O.s from all five panel review areas has been formulated into an Advisory Committee for Reorganization of the Health Care Foundation, and it is anticipated that the fruits of their efforts will be ready for presentation to both parent organizations sometime in the spring of 1974.

During the year, 1973, efforts were developed and are continuing in the Foundation's desire to be of service to the smaller community hospitals in updating their utilization review procedures. This has succeeded in its early efforts and has been instrumental in achieving more prompt reimbursement to such institutions, which previously had experienced delinquent payments from both Medicare and Medicaid intermediaries.

In the spring of 1973, another membership solicitation drive was held by mail. The current percentage of enrollees on a voluntary basis as Participating Members in the Health Care Foundation is approximately 60% of all identifiable practicing physicians, both Medical and Osteopathic, in the State of Missouri.

Ongoing discussions with the Division of Welfare relative to further activities in the Medicaid program of Missouri on the part of the Health Care Foundation have yielded considerably better dialogue, but no real involvement in the review process. The role which the PSRO movement will have in the State of Missouri on the Medicaid program is quite evident within the law, and such ongoing discussions obviously will be converted into important actions over the next two years.

In March, 1973, the report of the Health Care Foundation was presented to both the Missouri State Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons at their annual meetings, and delegate support for our activities was again expressed in formal resolutions.

Dr. Robert A. Slickman of Kansas City, Speaker of the House of Delegates for the 116th Annual Session of the Missouri State Medical Association.

Much activity was generated for the Health Care Foundation in May, 1973, wherein meetings were attended by Staff at the TAP meeting at the Lake of the Ozarks, the preliminary type of discussion involving both hospitals, the Joint Commission on Accreditation of Hospitals and medical societies. Contacts were made during this same month with all the elected Congressmen from Missouri regarding the impact that PSRO will have on the health care of the people in Missouri, expressing our attitude of cooperation, plus proposals regarding needed changes in the legislation in order to make it more workable at least within the confines of the State of Missouri.

At the meeting of the Board of Directors held in May, it was agreed that a management consultant firm should be sought to see if outside expertise would be available at a cost commensurate with our ability to pay in the development of coordinated efforts, not only as far as the Health Care Foundation is concerned, but each of its five constituent panel areas whose autonomy we were striving to improve and who would eventually need outside organizational help. A committee of the Board met with Uni-Med Services of Denver and with American Health Systems of California, exploring their previous experiences in developing peer review activities for medical societies under the umbrella of the foundation movement. Eventually the Board elected to engage Uni-Med Services, Inc. for a specified period of time and for a specified total amount of money to advise the Board on organizational matters. The Panel E area in the southeast portion of the state had already had discussions with Uni-Med, who had helped them structure and develop a potential foundation currently known as SEMO for the provision of appropriate peer review and in preparation of being structured to at least cope with the general outlines of the PSRO law. During the summer of 1973, Uni-Med made contacts within each of the five panel review areas with varying degrees of physician response. In addition, the Uni-Med consultants reviewed the proposed Bylaws and felt, as our legal counsel did, that the proposed Bylaws were entirely too detailed and that in our efforts to relate the Foundation to the total Missouri community, we had created a superstructure that would be difficult to manage. It was agreed by the Board that we would with-hold implementation of these Bylaws, give them further study and request that both the MSMA and the MAOPS rescind their actions of approval made in the spring of 1973. Thus, these new Bylaws were not implemented but were held in abeyance until the fall of 1973 when both parent organizations agreed, on the basis of arguments presented by the Health Care Foundation Board, to rescind their previous action and provide the Board with further opportunity to restructure the Bylaws and resubmit them for approval at a late date. This will be done, as already mentioned in this report.

A contract developed for mutual gain with Missouri Regional Medical Programs terminated in September, 1973 and in October, 1973, a new contract was developed for further support from MoRMP which will carry on until June 30, 1974. The future viability of the Regional Medical Program, of course, has a great deal to do with any further contractural arrangements which the Health Care Foundation may be able to develop with that office.

In late August, 1973, representatives of the Health Care Foundation Board met in Jefferson City with the officers and staff of the regional office of HEW at a public hearing which was called for expressions of all interested parties throughout the State of Missouri regarding the geographical distribution of PSROs within this state. The Health Care Foundation's proposal basically indicated the Foundation's willingness to be the primary contractor-administrator with HEW to implement PSROs in Missouri. Identification of five regional areas consistent in general with our previously delineated panel review areas was presented and clearly showed that the intent was to provide each region with complete autonomy as far as review is concerned and that the Health Care Foundation would provide consulting advice and assistance in the development and establishment of each PSRO. It was also presented that there would be an ongoing provision of services which logically would be better centered in a state foundation than burdening each local PSRO with such things as collation of data, data processing, supplementation of educational needs identified and offering a final appeal mechanism for all contested claims which could not be resolved locally. In this presentation, the Health Care Foundation identified itself as a peer review coordinating agency which would render itself capable of being the sole contractor in the State of Missouri for the provision of PSROs and would be bound to subcontract with each of the individual areas and appropriate funds to these areas to carry out their local functions. In addition to this presentation, there were supportive presentations from the Area Hospital Associations in Missouri, Missouri Osteopathic Association, Missouri State Medical Association and representatives from each of the five panel review areas wherein individual proposals for establishing themselves as PSROs were made, either as independent contractors with HEW or as subcontractees with the statewide Health Care Foundation of Missouri. It should be stated that this alternative was also included in the report of the Health Care Foundation wherein as an option they would serve under a subcontract with each of the designated PSROs, who would be the primary contractors with the Department of HEW. As is well known now, the Secretary did designate five individual PSROs in the State of Missouri which coincided exactly, county by county, with each of the five panel review areas as they were presented at this August 27 meeting referred to above to the representatives of the regional office of HEW. It should be stated parenthetically that there are several areas in the country, statewide, which did not receive as favorable consideration of their proposals by HEW as we did here in Missouri. These official designations were made on Dec. 19, 1973.

It is the opinion of the Board of the Health Care Foundation, and I think an opinion held by most of the physicians involved in trying to develop local PSRO activity across the state, that although the State of Missouri and the physicians and patients therein did receive favorable reaction to the proposals made by Missourians regarding geographical distribution, that there may well be considerable difference of opinion not only in Missouri, but all across the country when the final rules and regulations under which PSRO will be carried out and which may, indeed, call for much negotiation before any contractual arrangements are deemed fitting between any of our PSROs in Missouri with HEW.

During the last half of 1973, the Staff of the HCFM office was indeed very busy in each of the five panel review areas in rendering each of the areas conversant with the proposals that Uni-Med Services has been making and, in general, helping to generate the type of physician support which, of course, is vital to organizational success. All of the five areas are in varying stages of development. The southeast area of the state, formerly the Panel E area, has signed a contract with Uni-Med to help in carrying out their developmental and operational activities. It should be stated candidly that progress in all five areas has been advisedly slow, and in the opinion of the Board of Directors of the Health Care Foundation, we should all proceed cautiously and relate closely to each other as our directions are indicated and our plans are clear.

In October, 1973, the Health Care Foundation began negotiations with Blue Shield of St. Louis in an attempt to work out an arrangement whereby usual, customary and reasonable programs could be monitored for them by the Health Care Foundation, not only as it may relate to all of their business, but particularly regarding the CHAMPUS program, for which they are the carrier across the state.

In December, 1973, several activities took place. First, the Health Care Foundation moved its offices to a new address in Jefferson City, 211 East Capitol Avenue. Increased activity was conducted in each of the five panel review areas, but most particularly in Panel Review Area B. Here a steering committee was established by physicians in order to evaluate the future role of specific physician groups such as county medical societies, teaching institutions and associations in developing a PSRO in each area.

The Board of Directors met in early November, at which time the aforementioned reference to the unimplemented new Bylaws was taken, and it was referred back to the parent associations requesting that they rescind their previous action. They did, and the Advisory Committee on Reorganization of the Health Care Foundation was formulated. A second meeting of the Board was held by telephone conference in December wherein nominations from the Nominating Committee were selected to be passed on to the parent associations for election of new Board members. The new roster of the Board of Directors as it currently exists, with their terms of offices, are listed below:

	Term Expires:
Clement B. Grebel, M.D., Chairman	1976
Eugene W. Egle, D.O., Vice-Chairman	1975
Claus A. Rohweder, D.O., Secretary	1974
John I. Matthews, M.D., Treasurer	1974
Alfred D. Biggs, Jr., M.D., Director	1976
John M. Fry, D.O., Director	1976
Joseph L. Fisher, M.D., Director	1975
Francis M. Maple, M.D., Director	1975
Joseph B. Vacca, M.D., Director	1974

At the time this report was drafted, the future of PSROs, not only in Missouri but across the country, is still in a considerable state of flux. It can be stated that the activities of organized medicine at the national level have indicated considerably more interest and concern on the part of physicians in general regarding the implications of this law. Many very cogent amendments have been developed and are being pursued through the legislative channels in Washington to hopefully achieve revisions of the provisions of PSRO which will not only make them more workable, but what is probably more important at this stage in time, more palatable. The members of the Board of the Health Care Foundation have been extremely diligent in trying to keep as fully aware and informed of the ongoing evolutions in the PSRO arena. They are fully cognizant of what is disturbing most physicians and are encouraged by the strong probability that the Health Care Foundation may be able to satisfy many of these concerns.

One philosophy which has been expressed to the Board is that the viability of the PSRO legislation and its overall mandated activities may ultimately prove to be unworkable and that peer review efforts on the part of organized medicine and osteopathy must continue to be developed, refined and sophisticated so that the desired goals, as stated by physicians throughout the country regarding the need for and the desirability of peer review, may still be implemented outside of any legislative action. It is felt by many that the strengthening of peer review may well be one of the long term, strongest actions that physicians can take against those features of the PSRO law which are currently looked upon with so much disfavor by providers of health care.

The years 1974 and 1975 promise to be ones of great revolution, increased understanding and hoped-for response by our elected representatives as well as by our fellow physicians and the public as we all relate to the quality and cost of health care, its delivery and availability.

Hector W. Benoit, Jr., M.D.

(Referred to the Reference Committee on Resolutions.)

Reports of Officers

REPORT OF THE SECRETARY

The Missouri State Medical Association had 4,469 members as of Dec. 31, 1973. This was an increase of 41 members over the previous year.

MEMBERSHIP CHANGES DURING THE YEAR

Members, Jan. 1, 1973		4,428
New Members admitted during year	232	
Reinstated	16	
Total added	248	
Members dropped during year	40	
Deceased	90	
Transferred to other states	67	
Resigned	10	
Total lost	207	
Net Gain		41
Members, Dec. 31, 1973		4,469

The Committee on Nominations, which is appointed by the President from the House of Delegates, must submit nominations for the following offices:

Three Vice-Presidents to fill the expired terms of Rae W. Froelich, Lebanon; R. Lee Cooper, Warrensburg; Robert W. Kelley, St. Louis.

A Speaker of the House of Delegates and a Vice-Speaker of the House of Delegates to fill the expired terms of Robert A. Slickman, Kansas City, Speaker, and James T. Brown, Springfield, Vice-Speaker.

Two Delegates and corresponding Alternates to the American Medical Association to fill the vacancies created by the expiration on Dec. 31, 1974, of the terms of Delegate, Stanley S. Peterson, Springfield; Alternate, James C. Sisk, Clayton; Delegate, J. Loren Washburn, Versailles; Alternate, Rae W. Froelich, Lebanon.

The terms (two years) of the Councilors of the odd numbered districts expire this year. These Councilors are: John N. Martin, St. Joseph, First District; Max S. Franklin, St. Louis, Third District; Robert E. Bregant, Jefferson City, Fifth District; R. Allen Chandler, Kansas City, Seventh District; Claude W. Cooper, Thayer, Ninth District. Delegates from these districts shall meet during the meeting, prior to the last day, and elect the Councilor for their district. The election shall be certified to the House of Delegates on a prescribed form which will be furnished.

The entire session will be held in the Crown Center Hotel, Kansas City. The House of Delegates will hold its first session on Thursday, April 4, at 1:30 PM in the Century

One hundred and fifty-one delegates, nine officers and ten councilors were present for the opening session of the House of Delegates on April 4, 1974 during the first

MSMA Annual Sesison to be held at the Crown Center Hotel in Kansas City.

Room. Reference Committees will meet in committee rooms in the hotel. The second session of the House of Delegates will convene at 4:00 PM, Friday, April 5, in the Century Room. The final session of the House, a breakfast meeting, will be held in the Century Room at 7:30 AM on Sunday, April 7.

Registration facilities will be open on Thursday, April 4, from 11 AM to 4 PM; on Friday and Saturday from 8 AM to 5 PM, and on Sunday from 7:30 AM to 9 AM. Registration will be in the Century Foyer.

John I. Matthews, Secretary

(Referred to the Reference Committee on Report of Officers.)

REPORT OF THE TREASURER

The report of the Treasurer is covered in the Financial Statement which appeared in the March issue of Missouri Medicine and is included in the Delegates' Handbook. Therefore, it is not repeated here.

Donald R. Judd, Treasurer

(Referred to the Reference Committee on Reports of Officers.)

REPORT OF EXECUTIVE SECRETARY

Your staff moved into the new MSMA Headquarters Building at 113 Madison Street in the Capital City on May 1, 1973. We are pleased with our new facilities and have noted many complimentary comments from those who have visited the office, particularly members of the Association and their wives. Our new location has proven to be extremely advantageous in our major staff activities.

Your headquarters staff has worked hard the past year on Association activities under the direction of the Officers, Council and Committees and Commissions of the Association.

During the 1973 Regular Session of the Missouri Legislature, some 75 bills affecting Medicine were followed closely by members of the MSMA staff. Many physicians from various parts of the state were scheduled to appear before legislative committees who considered many of these bills. A Special Session of the Legislature was called in December, 1973 and the regular 1974 session began in early January. A total of some 100 bills affecting Medicine in these sessions occupied and are occupying a great amount of staff time and effort. Educational activities relating to many of these bills are continuously carried on.

Continuous contact has been and is being carried on with Missouri's ten members in the U. S. House of Representatives and with our two U. S. Senators on specific Health Legislation on the federal level. Royal O. Cooper, Assistant Executive Secretary, heads up our staff activities relating to Health legislation.

Foreign Tours for members of MSMA have now become a part of the Association's activities program. Information on scheduled tours appears in Missouri Medicine from time to time as well as special mailings to the membership.

Other activities of the staff are associated with projects and programs of various Committees, Commissions and the Council which are reported through the written reports in your Delegates' Handbook and have been presented in Missouri Medicine.

A continuous effort by staff, particularly Royal O. Cooper, to assist physicians who contact the Association office to find suitable locations, consumes considerable time and effort. Communities seeking physicians along with medical groups and established physicians desiring associates are assisted whenever possible.

It is the considered opinion of your Executive Secretary that greater success must be achieved in this state, possibly through better cooperative efforts on the part of numerous organizations, groups and agencies in securing more physicians for some of our towns in Missouri outside of metropolitan areas and larger towns or cities in the so-called outstate Missouri. Our Association needs to give a high priority in its program and projects to help fulfill this state need.

Members of our staff, particularly Tom P. Fox, assumes considerable responsibility in the administration of the Missouri State Medical Foundation, your State Medical Association Medical Student Loan Program. He has done a fine job under the direction of the Loan Foundation Board of Trustees. More detailed information concerning the Medical Student Loan Program is given in the Annual Report of the MSMF appearing in your Delegates Handbook. He has also worked very hard on the many details and the programs for the 1974 Annual Meeting.

Cork Swarens will have been on our staff for two years as of June 1, 1974. He handles Public Relations and Membership Communications for us and does it well. We are most pleased to have him on our team.

Miss Jean Duensing, Managing Editor of Missouri Medicine, working closely with Joseph V. Finnegan, M.D., Editor, publishes a monthly scientific Journal which is now considered high on the list of well recognized State Medical Society Journals.

Mrs. Rose Mahon serves as Office Manager and does everything well that needs to be done around a busy office.

Mrs. Wilma Sperry is our bookkeeper and her importance to our operation is nondebatable. Our CPA firm fully agrees with this.

Mrs. Ruth Pack is right hand to Tom Fox in taking care of the Missouri State Medical Foundation details, along with many other secretarial duties which she handles competently.

Miss Linda Bremer works closely with Mrs. Mahon and also does everything well that needs to be done in the secretarial line in our office.

Mrs. Fran Roedel and Miss Sharon Champagne, newer additions to our staff, handle competently the variety of office assignments given them from day to day.

I assure all of the members of the MSMA that you have a competent, dedicated, hardworking staff.

Raymond McIntyre, Executive Secretary

(Referred to the Reference Committee on Reports of Officers.)

Reports of Standing Committees

REPORT OF COMMITTEE ON CONSTITUTION AND BYLAWS

The MSMA House of Delegates at the 1973 Annual Session adopted the report of the Reference Committee on Constitution and Bylaws concerning Resolution #13. It was pointed out that because the Speaker and Vice-Speaker are not elected at the same time as other Delegates, it would be possible to have either the Speaker or the Vice-Speaker not elected as delegates with the result that the House of Delegates would be without these officers. The Reference Committee recommended that the Constitution be changed to provide that the Speaker and Vice-Speaker shall serve as delegates-at-large.

> The Committee recommends that Article IV of the Constitution be amended by inserting a comma following the word "Association" and adding the following words "the Speaker and Vice-Speaker." This sentence would then read, "The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker, who will serve as delegates-at-large."

The Committee also suggests that if the change in the Constitution is adopted, a corresponding change be made in the Bylaws. Chapter III, Section 2 of the Bylaws should be amended by inserting a comma and the following words, "the Speaker and Vice-Speaker" following the word "Association" in the last sentence. The sentence would then read "All Past-Presidents of the Association, the Speaker and Vice-Speaker, shall serve as delegates-at-large."

Again, it is emphasized that this change is recommended because it is conceivable that the Speaker or Vice-Speaker of forthcoming Annual Sessions would not be elected a delegate by his component society and the MSMA Constitution stipulates that the Speaker and Vice-Speaker must be elected from the body of the House of Delegates.

We call your attention to the constitutional amendment recommended by the Committee on Constitution and Bylaws and adopted by the House of Delegates at the 1973 Annual Session. This proposed amendment to the Constitution will be voted on at the 116th Annual Session. The amendment reads as follows:

> "Petitions signed by 10% of the active members of the Association, including petitioners representing at least one half of the component Medical Societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question."

Miles C. Whitener, Chairman
R. Stacy Long
Donald R. Judd
Joseph Conrad
Edwin M. Powell

(Referred to the Reference Committee on Constitution and Bylaws.)

REPORT OF COMMITTEE ON LEGISLATIVE AFFAIRS

As this House of Delegates convenes, the Second Session of the 77th Missouri General Assembly begins its final four weeks of deliberations.

Prior to the current Legislative Session, the Committee on Legislative Affairs considered appropriate medically-related legislation and secured representatives and senators to introduce bills.

In the last three months, the Committee has provided witnesses and written testimony before Legislative Committees considering measures of interest to medicine. We have expressed support of some bills and opposition to others. In all, this Committee and MSMA Staff have followed 78 House bills and 17 Senate bills to varying degrees during this Session.

In the next four weeks, it will be necessary for your Committee and MSMA Staff to maintain almost constant watch on the medically-related bills still being considered by the Legislature.

The advent of Annual Legislative Sessions three years ago has precipitated almost year-round activity for this Committee and Staff. Our principal objective is to support good health legislation and oppose those measures which would be detrimental to our patients and the practice of medicine.

This Committee feels compelled to reiterate its concerns expressed last year on lack of physician participation in governmental and legislative matters on the local, state and national scenes. It is obvious when dealing with Legislators that many organizations in Missouri of lesser size and respect than the MSMA, command much attention in the Capitol through effective member participation on matters of concern.

MSMA members should be aware that the impact this Association yields is not necessarily dependent upon our numbers, but upon the amount of involvement in legislative and political affairs. We again urge all physicians to become interested in and stay abreast of legislative matters and to regularly communicate their opinions to their respective Legislators.

This Committee expresses its sincere appreciation to those physicians who have given freely of their time and expertise in advising the Committee on Legislative Affairs, presenting testimony at Legislative Hearings and contacting their Legislators on medically-related bills.

John I. Matthews, Chairman
R. Allen Chandler
James C. Cope
Robert E. Bregant
Lawrence E. O'Neal

(Referred to the Reference Committee on Miscellaneous Affairs.)

REPORT OF COMMITTEE ON PLANNING

The Committee is making the following recommendations:

Recommendation #1—It is recommended that the $10 per year assessment on each active member of the Association for the Missouri State Medical Foundation be continued for another three-year period. It is further recommended that the interest rate structure for loans be changed as follows: 2% interest rate to day of graduation from medical school; 5% interest rate for the next two years; 8% interest rate thereafter.

It is noted that the Foundation now has approximately $500,000 in outstanding loans. In 1972, the assessment was $37,420, contributions were $5,153 and approximately $71,000 of loans were made. Repayments consisting of $18,300 in principal and $5,155 in interest were made. A total of 119 loans were granted.

The Committee feels that by increasing the interest rate, loans will be repaired more quickly and that, at some future date, the active member assessment could be removed.

Recommendation #2—It is recommended that two field secretaries and one additional office secretary be employed by MSMA.

The above recommendation is made to enable the Association to improve in the area of communications. Members appear not to know or understand what is going on at the state and national level in organized medicine. It is believed that the two field secretaries could be active throughout the state appearing before county medical societies, Councilor District meetings and for those who cannot be reached through these organizations, the men should talk to them in their offices. A goal of this project would be to reach those outside the mainstream of organized medicine. It is estimated that $45,000 should be budgeted for this project.

Recommendation #3—It is recommended that funds be made available to the Council for the Councilors to use in communicating with their constituents.

These funds could be used by the Councilors in disseminating information within their Councilor Districts. It is believed that personal letter on a Councilor's letterhead and in his envelope is a most effective means of communication. Each Councilor should have adequate funds to contact every member in his district at least twice a year.

Recommendation #4—It is recommended that a MSMA policy manual be developed.

The policy manual would consist of a review of the actions taken during the Annual Meeting of the MSMA House of Delegates and of the minutes of Council meetings to condense MSMA policies into readable form and easily codify the positions that the MSMA has taken on major issues. Any physician in this state would then be able to state immediately the official policy of the Association.

Recommendation #5—It is recommended that the Planning Committee be authorized to study additional benefits and services for the membership.

Additional benefits and services for the membership could not only be of value to the membership, but could result in income to the Association. It was noted that the AMA develops approximately 50% of its income from areas other than dues. Some of the services that could be provided include automobile leasing programs, developing our own professional liability insurance company group, term life insurance, group cash reserve insurance (permanent insurance), group automobile insurance and a membership retirement plan.

Recommendation #6—It is recommended that some type of recognition be developed for our members who serve on Committees, Commissions, as Councilors, Officers and AMA Delegates and Alternate Delegates.

Perhaps some type of certificate of service could be designed to present to members in recognition of their work.

Recommendation #7—It is recommended that MSMA dues be increased $25 annually, effective Jan. 1, 1975.

Our present dues structure is $65 annually. Also, on the dues statement is a $10 active membership assessment for MSMF. If this recommendation is implemented, the dues would be $90 per year and if the assessment to MSMF is continued at the $10 rate, this would result in a total billing of $100 per year for each active member. A broad program of development will require additional funds. The Committee feels that the members will be willing to vote the necessary financial assistance if it is presented with an organized program.

David N. Kerr, Chairman
T. N. Cofer
Paul H. Rother
William D. Bradshaw
J. Will Fleming
Oral B. Crawford
James A. Hasek
Hector W. Benoit, Jr.
Charles P. McGinty
James C. Cope

(Referred to the Reference Committee on Reports of Officers.)

REPORT OF COMMITTEE ON PUBLICATIONS

The 70th volume of Missouri Medicine was completed with the prublication of the December, 1973 issue. During the year, 13 issues were printed and distributed. Eleven of this issues contained scientific pages, special articles, organizational reports, monthly messages from the Presidents of the Association and the Woman's Auxiliary and news and other items of interest to members of the medical profession The July 1 issue contained the official proceedings of the 1973 (115th) Annual Session of the MSMA House of Delegates. The July 15 issue was the annual Membership Directory.

There was one special issue of the Journal. The scientific articles in the April issue were contributed by members of the faculty of the University of Missouri-Columbia School of Medicine.

In the May issue, Missouri Medicine published a study which represents the first new major data collection and analysis effort of the Missouri Center for Health Statistics, which is jointly sponsored by the State Board of Health and the Governor's Advisory Council for Comprehensive Health Planning. After publication in the Journal, the study was reprinted in booklet form by the Missouri Division of Health for further distribution.

During the year, 51 scientific papers and seven special articles were published. Most of the articles were written by Missouri authors.

The Editors wish to express appreciation to all authors who submitted scientific manuscripts and to all other individuals, institutions and organizations, including the administrations, faculties and publications departments of the University of Missouri in Columbia and Kansas City, St. Louis University, Washington University and Ellis Fischel State Cancer Hospital for their valuable contributions.

At the year's end, the Journal circulation was 5,000.

The complete financial report for the Journal is included in the financial statement for the Missouri State Medical Association for the year 1973. The report was published in the March, 1974 issue of Missouri Medicine and is included in the Delegates' Handbook.

Joseph V. Finnegan, Chairman
William C. Mixson
Charles S. Sherwin
Byron M. Stuart
Wilfred E. Wooldridge

(Referred to the Reference Committee on Reports of Officers.)

REPORT OF THE COMMITTEE ON VOLUNTARY HEALTH AGENCIES

On Dec. 16, 1973 the Committee on Voluntary Health Agencies met with Representatives from 11 Missouri Voluntary Health Organizations in Jefferson City, Missouri.

The following organizations were represented:

Missouri State Diabetes Association
Arthritis Foundation of Missouri
Missouri Public Health Association
American Lung Association
Missouri Division of the American Cancer Society
Missouri Society for Crippled Children and Adults
Missouri Heart Association
Missouri Association for Retarded Children
Missouri Association for Mental Health
Missouri Association for Social Welfare
United Cerebral Palsy Association of Missouri

The purposes, needs and aims of each of the organizations were brought before the Committee.

Labeled as a "First" by many representatives, the meeting provided a forum wherein each agency could explain its program to the physicians of Missouri, and equally important, have the opportunity to discuss mutual interests with representatives from other voluntary health agencies in the state.

Along with presenting the purpose, size, type of membership and current activities of the voluntary health agencies, each representative was requested to express his opinion as to how the MSMA might best assist that agency. This segment led to the following recommendations:

1. Physician involvement in voluntary health organizations both as members and to provide expert medical advice and guidance is essential.
2. Physicians need to be better informed on what services the agencies offer and, as a result, give their patients the opportunity to benefit from the services by referring the patient to the proper agency.
3. Physician support for an agency's community service program greatly enhances the prospect for success of the program.

4. Better liaison between physicians and voluntary health organizations should be a prime goal.

5. That benefit should be gained from a similar meeting to this one on an annual basis.

The Committee on Voluntary Health Agencies of the MSMA, therefore, makes the following recommendations:

1. Physician-members of the Voluntary Health Organizations should be encouraged to submit appropriate articles to Missouri Medicine for consideration for publication that could include what the voluntary health agency offered to aid a physician's patient.

2. The assignment of an MSMA staff member to be a contact point for voluntary health organizations with the MSMA office.

3. That the MSMA give favorable consideration to publiation of a "Directory of Voluntary Health Organizations" similar in format to the AMA publication on National Voluntary Health Agencies to be distributed to the membership for their use and that this be updated annually.

W. C. Allen, Chairman
Joseph L. Fisher
Paul S. Quinn
Carl Siegel
Melvin A. Cassel

Referred to the Reference Committee on

Reports of Commissions and Ad Hoc Committees

REPORT OF THE COMMISSION ON PUBLIC AFFAIRS

(This report includes all reports of ad hoc committees set up under this Commission.)

The MSMA Commission on Public Affairs, a Commission which handled many projects the past few years, took a backseat to socio-economic and governmental issues during 1973.

Many of the projects initiated by the Commission in previous years were continued during 1973 but, regretfully, the priority project approved by the Commission for 1973 had to be scuttled.

In responding to the House of Delegates' desire to provide greater exposure to and knowledge of the Missouri Political Action Committee, the Commission on Public Affairs proposed to sponsor a "MMPAC Workshop" on February 2 at Jefferson City to replace the annual Public Affairs Conference. Although the Commission believes the Workshop would have helped carry out this House's desires, the advance registration of just 20 physicians failed to justify the cost of the affair. Therefore, the Workshop was postponed.

On a more positive note, a report issued by the Missouri Department of Education indicated that more than 2,500 parents, teachers and school administrators were reached by the Venereal Disease Project cosponsored by this Commission, the Division of Health, the Department of Education and the Missouri Parent-Teachers Association during the late spring months of 1973.

The VD Project is the first step in a five year program planned to develop comprehensive health education materials for the schools in Missouri. Work on this project will continue during 1974 with the emphasis being placed on drugs and alcohol.

Other items acted upon during the past year include the recommendation of continuing the Public Affairs Breakfast at the MSMA Annual Session in conjunction with the Woman's Auxiliary; continued support of those Regional Medical Programs previously endorsed; commendation of the West Central Missouri Medical Society and other component societies for sponsoring effective Medical Aspects of Sports meetings with area coaches; and recommendation for dissemination of timely medically-related News Releases of interest to the public.

In his official report to the House of Delegates, President E. A. Stricker reminded the delegates that the MSMA "was originally chartered on the concept that it would represent its members and that concept has not and should not be changed."

Following this report are supplementary reports from the Commission's Ad Hoc Committee on Medical Aspects of Sports and Ad Hoc Committee on Emergency Medical Services.

Richard P. Bowles, Chairman
Byron E. Watts
Hubert A. Ritter
James C. Denninghoff
Richard A. Sutter
Troy Morgan
R. A. Ritter, Jr.
C. Keith Whittaker
Stanley G. Hall
J. E. Block
Joseph Kendis
W. W. Tillman, Jr.
John L. Barnard, Jr.
Allen P. Klippel
Joseph Zimmerman

REPORT OF AD HOC COMMITTEE ON EMERGENCY MEDICAL SERVICES

The Chairman of this committee has been appointed to the permanent advisory committee on Emergency Medical Services by Governor Bond, and detailed plans for development and implementation of a statewide system for Emergency Medical Services are being developed.

The Committee will prepare several resolutions to be presented to the House of Delegates of MSMA at the Annual Meeting. These recommendations will incorporate:

1. Evaluation of hospital emergency capability by a statewide survey.

2. Assistance in development of adequately trained ambulance personnel with proper equipment and vehicles.

3. Seat belt legislation to reduce highway deaths and injuries, as well as make the state eligible for the 25% increase in federal money such legislation provides.

Allen P. Klippel, Chairman
Marshall Conrad
John Wallace
Louis P. Hetlage
Frank B. Matteson
Frank L. Mitchell
James D. Dexter
John T. Crowe
Thomas J. Fischer
John L. Barnard, Jr.
William H. Snead, Jr.
James R. Cook
Robert Burdge

REPORT OF AD HOC COMMITTEE ON THE MEDICAL ASPECTS OF SPORTS

The Ad Hoc Committee on the Medical Aspects of Sports has no recommendations this year. We are currently involved in the feasibility of drug studies and, also, the heat exhaustion and physician coverage in secondary schools in Missouri.

Donald M. Spencer, Chairman
H. Peter Ekern
David W. Brown
E. T. Hansbrough
Philip C. Lehman
Edwin C. Ernst, Jr.

(Referred to the Reference Committee on Miscellaneous Affairs.)

REPORT OF THE COMMISSION ON MEDICAL ECONOMICS, THIRD PARTY MEDICINE AND GOVERNMENTAL RELATIONS

(This report includes all reports of ad hoc committees set up under this Commission.)

The Commission, in January, made the following recommendations and statements to the Council:

1. The Commission recognizes the gross inequities of third party fee payments in Missouri. The Commission feels that a physician should handle any payment that he believes to be inequitable through proper channels.

2. It is recommended that an analysis and summary of pertinent national health insurance bills be published in Missouri Medicine at an early date.

3. It is recommended that the major health insurance carriers be contacted to obtain their contract coverage code concerning contract benefits. If these contract codes were available to individual physicians, it would greatly assist public relations and service among physicians, patients and carriers.

4. It is recommended that the problems between physicians and the Aetna Insurance Company be pursued further.

5. It is recommended that an MSMA survey be made concerning the delay of payments by carriers. The survey should be statistically oriented to cover solo practitioners, groups and the various specialties. Information should be obtained concerning the seven or eight larger carriers. It should ask for the number of days from the date the claim was filed until the payment was received by the physician.

6. It appears that there seems to be a growing practice for insurance companies, their agents, employees, investigative organizations and other third parties in connection with obtaining medical data to simply photograph physicians' patient medical records. This practice is obviously a convenient method to obtain information but, simultaneously, it permits access to substantially greater amounts of information than is necessary or is intended through the release authorized by the patient. The AMA Council on Medical Service has an ongoing program to examine and explore possible solutions to the various problems inherent in this subject. They feel strongly that the preservation of the confidentiality of medical information developed during the course of the physician-patient relationship is an ethical obligation of the medical profession.

7. It is recommended that physicians be encouraged to participate and become active and informed in comprehensive health planning programs. They should fully recognize the importance of CHP as a force in the health system—now and in the years to come.

8. The Chairmen of the Commission will appoint an ad hoc committee to study renal dialysis and transplants under Medicare and the AMA House of Delegates policy to oppose retainer type fees and to make recommendations to the Council at a later date.

9. Dr. Heeb's report of the Advisory Committee to the Missouri Division of Welfare was accepted with commendation. His report is attached. It is recommended that the following resolution be submitted to the MSMA House of Delegates.

Whereas, Some physicians have been dropping out of the Medicaid Program because of inconsistent payments of services, unrealistic denial of coverage of many services and retroactive denial of payments; and

Whereas, Many of the Services retroactively denied are overhead items to the physician making it possible for him to actually lose money in the program; and

Whereas, The dentists have a definite fee schedule; and

Whereas, The Welfare recipient in the State of Missouri is finding it increasingly more difficult to find adequate medical care; therefore, be it

Resolved, That the Missouri State Medical Association approve the negotiation of a definite fee schedule and list of ancillary services provided for Title XIX recipients; and, be it further

Resolved, That the negotiated fee schedule be renegotiated on an annual basis.

It is understood that this will need to be done under the framework of present laws concerning antitrust and restraint of trade.

10. It is recommended that MSMA make known its opposition to the *Federal Register* notice requiring pre-hospital admission certification and that a letter of such opposition be sent to the Social Security Administration Washington Office, and that, additionally, we recommend the Council contact members of the Missouri Congressional delegation and inform them of our opposition.

11. The Commission agreed wholeheartedly with the recent MSMA Council action on PSRO and recommended that it be supported. This position is "That the Council believes that the PSRO law should be repealed or effectively amended and work actively with the Missouri Congressional delegation to this end."

12. The Commission has submitted a resolution to the MSMA House of Delegates concerning the actions of the Cost of Living Council and Physicians' fees.

Stanley S. Peterson, Chairman
Max A. Heeb
Kenneth K. Keown
Rae W. Froelich
E. J. Cunningham, Jr.
Francis M. Maple
Herbert C. Wiegand
Victor B. Buhler
Mark D. Eagleton
E. E. Wadlow
Rolla B. Wray
Charles W. Chastain
Blaine Z. Hibbard
E. Warren Allen
Robert H. Lund

REPORT FROM MSMA REPRESENTATIVE TO MEDICAL ADVISORY COMMITTEE MISSOURI DIVISION OF WELFARE

The topics discussed were inpatient hospital care, outpatient hospital care, mental hospitals, skilled nursing homes, prescription drugs, dental care, physicians' services, laboratory and x-ray outside hospital and physicians' offices, emergency ambulance service, home health services, early screening diagnosis and treatment, optometric services and family planning.

A new program which will be in operation on Jan. 1, 1974 for medically indigent persons becoming eligible for Title XIX medical assistance through a process known as "Spend-down." In order to qualify for this program, one must satisfy the criteria of a rather complicated formula including their income, medical expense, real estate and other assets owned. This might be one to watch. They project the budget for "Spend-down" to be $12,404,624 for fiscal 1974-1975 out of the total $91,722,344 budget.

The increase to existing programs is only 0.86% over the planned expenditures for fiscal year 1973-1974.

The volume of services paid to physicians participating in Title XIX remained stable between fiscal 1971-1972 and fiscal 1972-1973. There was a 5.4% increase for the total payments. This increase resulted primarily from higher charges for both medical and surgical fees as a result of restoring the 5% cut in professional fees on July 1, 1972. In other words, we did not actually have a raise—we were just put back at the same level that we were. An increase in the Medicare Part B deductible from $50 to $60 per year contributed also to a total of the 5.4% increase. The total physician expenditure in fiscal 1972-1973 was $11,691,754 as compared to the projected 1974-1975 hospital care budget of $39,167,595 excluding mental hospitals and nursing homes.

A new program added to Title XIX for nursing home patients is called ICF or Intermediate Care Facility requiring less medical care than skilled nursing. There are approximately 115 homes which would be eligible for the ICF program as compared to 112 skilled facilities. They also estimate that the "Spend-Down" program will add about 1,756 ICF patients at a cost of $6,025,875.

The family program under which the federal government pays 90% of the costs is anticipated to grow 22% with a total cost estimate for the next year to be $464,370.

Another mandatory federal program is the Early Screening Diagnosis and Treatment Program. There are 197,632 children under 21 years of age on the Welfare rolls who are offered this service once per year. About 50 of the patients contacted thus far want to use this service. It is estimated that approximately 98,816 children will be screened at a cost of $15 each and a total cost of $1,482,240 per year. Eyeglasses will add another $454,540, which is a new federal requirement. Hearing aids is estimated to be $395,200. The total estimated cost of this program is $2,331,980 or about $1 per month per child on ADC.

It is my impression that many physicians were dropping out of the Medicaid Program because of inconsistent payments for the same service by the same physician, many times for the same diagnosis. Also, retroactive denial of payments as well as arbitrary taking injections off the payment list because of some abuses to things like B-12. It appears that the new director is willing to talk about a fee schedule for physicians (the dentists have had one for some time).

It seemed to be the impression of some members of the Medicaid staff at least that HMOs and foundations had reduced medical costs on the basis of preventive medicine. It was pointed out that most instances in which any medical costs had been reduced had been a matter of transfer of care from the hospital to the physician's office or home by providing outpatient benefits and discouraging unnecessary hospital admission.

Your representative urged that the Medicaid people explore a pilot study to see if costs in an area could not be reduced by providing some realistic outpatient coverages that the physician could depend upon and not risk retroactive denial of payment and arbitrary payments. It was submitted that their reasons for not having done this in the past was the fear of overutilization in an area where there was really no adequate peer review. It was suggested that they consider the Southeast Missouri Foundation for Medical Care or any other similar organizations that are developing in the state as a one-year pilot study. They seemed to be unknowledgeable about this type of operation but are willing to discuss it where they have not been willing to before.

Max A. Heeb, M.D.

(Referred to the Reference Committee on Resolutions.)

REPORT OF THE COMMISSION ON CONTINUING EDUCATION AND HEALTH MANPOWER

(This report includes all reports of ad hoc committees set up under this Commission.)

The Commission on Continuing Education and Health Manpower appointed three Ad Hoc Committees as follows: Ad Hoc Committee on Continuing Medical Education, Ad Hoc Committee on Health Manpower and Ad Hoc Committee—116th Annual Session. The Ad Hoc Committees implemented directives of the MSMA Council and worked closely with allied health services in the study and solution of problems referred. Specific details of Committee action can be found in the individual Ad Hoc Committee Annual Reports published herein.

The Commission worked closely with the Commission on Interspecialty Medicine in further study and planning of a new statewide program on Continuing Medical Education and in the development of Scientific Sessions for the 116th Annual Convention.

George H. Ladyman, Chairman
Andrew McCanse
A. Sherwood Baker
Richard J. Dames
John C. Soucy
Charles A. Worley
H. Peter Ekern
B. J. Bass
Paul R. Young
Lucien W. Ide
Richard A. Fraser
R. E. Catanzaro
W. Thomas Morgan, Jr.
W. Wayne Boydston
Charles Spears

REPORT OF THE AD HOC COMMITTEE ON HEALTH MANPOWER

The Ad Hoc Committee on Health Manpower presented to the Commission on Continuing Education and Health Manpower final draft of resolutions (guidelines) on policy concerning the Registered Nurse and (1) use of intracardiac injection of drugs and (2) use of endotracheal intubation. These guidelines were accepted by the Commission, and with a minor revision, approval by the MSMA Council in session Dec. 15, 1973. Chairman of the Ad Hoc Committee on Health Manpower has been appointed to serve as MSMA's representative to the Advisory Board of the Mid-Missouri Community Based Allied Health Education Manpower Program.

When he addressed the House of Delegates, President-Elect James C. Cope discussed "a program of action" which would be presented to the House for its consideration.

The Ad Hoc Committee expresses appreciation to the parent Commission and the MSMA staff for their cooperation and assistance.

Charles A. Worley, Chairman
B. J. Bass
A. J. Signorelli
Richardson K. Noback
William C. Allen
Roman E. Hammes

REPORT OF THE AD HOC COMMITTEE ON CONTINUING MEDICAL EDUCATION

The Ad Hoc Committee on Continuing Medical Education met two times in 1973. The first meeting on May 19 consisted of a joint meeting with members of the Commission on Interspecialty Medicine. Discussion related to the proposed plan for Continuing Education of MSMA and, particularly, the role of the Specialty Societies in the implementation and support of the proposed program. It was resolved that each recognized Specialty Society would be asked to indicate its willingness to prepare guidelines for the quantity and quality of CME for their respective specialty. Responses to this request were to be obtained by Jan. 1, 1974.

The second meeting of the committee was on Sept. 9, 1973. At this meeting, details of the proposal were addressed. Specifically, the roles of the District CME representatives, the Ad Hoc Committee on CME, the Executive Director of CME, the Commission on Continuing Education and Health Manpower, the County Medical Societies and the Commission on Interspecialty Medicine were discussed. Further, a tentative expense budget was formulated.

On Nov. 11, 1973, the proposal was presented to the Commission on Continuing Education and Health Manpower for its review and approval and, thereafter, accepted with commendation by the MSMA Council in session Dec. 15, 1973. Attached herewith is the proposal and recommended budget in detail.

Paul R. Young, Chairman
A. Sherwood Baker
George H. Ladyman
W. Wayne Boydston
Robert S. Mosser
Kirby L. Turner
Thomas J. Mitchell
Arnold Block
Marvin A. Singleton

PROPOSAL FOR CONTINUING MEDICAL EDUCATION

OBJECTIVE: The objectives of this proposal are:

1. To provide for a system by which the State Medical Association can encourage physicians to seek and obtain effective and efficient continuing medical education.
2. To provide a system by which the State Medical Association can be of assistance to its membership to identify the educational needs and desires of its membership.
3. To provide a system of accounting for the educational activities of the membership of the State Medical Association.
4. To provide realistic educational goals for the membership of the State Medical Association.
5. To provide a system of accreditation of educational programs for physicians in the State of Missouri.
6. Through effective Continuing Education, to elevate the quality of Medical Care received by the Citizens of the State.

GENERAL PRINCIPLES

1. CME should be related to patient care.
2. CME is usually most effective when it occurs in the practice setting.
3. CME should be evaluated for both process and outcome.
4. The State Medical Association has a definite role in CME
   a. To assist the membership to identify their needs and desires.
   b. To assist the membership in development of effective CME programs.
   c. To assist the membership in obtaining appropriate educational resources.
   d. To assist the membership in evaluation of their CME.
   e. To assist the membership in accounting for their CME.
   f. To provide a model which can be used by other State Medical Associations.
5. Physicians' educational needs vary considerably depending on specialty, location of practice, time limitations, practice patterns and other factors.

PROPOSED PROGRAM STRUCTURE

See Fig. 1.

FUNCTIONS

Hospital DME

There should be a person designated on the medical staff of each hospital whose responsibility is to assist the members of that hospital staff to identify their educational needs, to arrange for programs to meet the needs, assist in evalua-

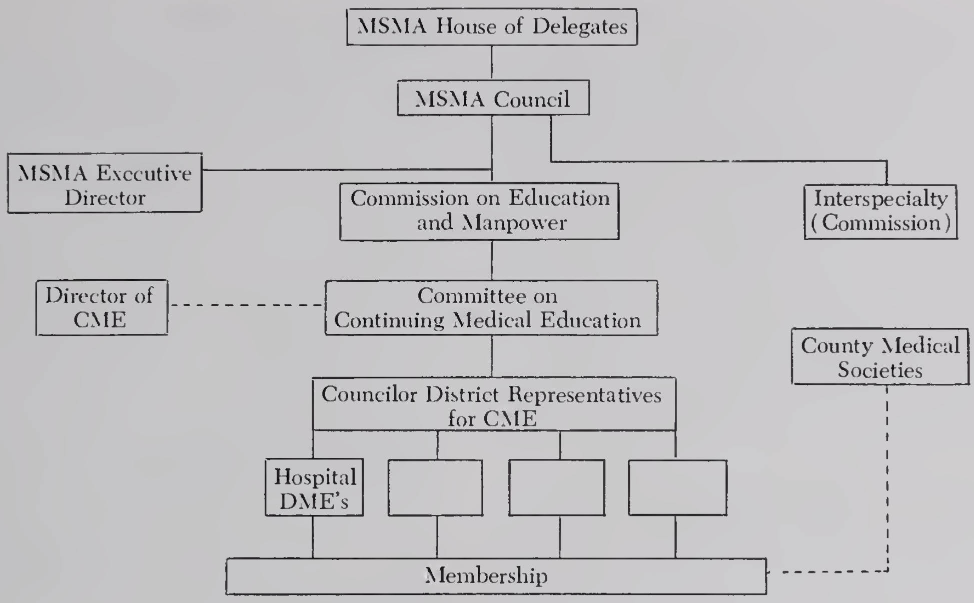
MSMA House of Delegates
MSMA Council
MSMA Executive Director
Commission on Education and Manpower
Interspecialty (Commission)
Director of CME
Committee on Continuing Medical Education
County Medical Societies
Councilor District Representatives for CME
Hospital DME's
Membership

Fig. 1

tion of process and outcome and to stimulate interest in CME.

Councilor District CME Representative

Each Councilor District now has a person designated to assist the Hospital DMEs to perform their tasks. He functions as a consultant, a catalyst and a coordinator. When several hospitals identify a common need, he tries to promote cooperative efforts to conserve resources. He has district-wide responsibilities similar to those of the Hospital DME. Each councilor district representative should remain in office for at least three years.

Committee on CME

Composed of the ten Councilor District CME Representatives, this committee meets regularly to identify common problems and seek appropriate solutions. It should seek ways to conserve resources by promoting cooperative efforts among Councilor Districts. It should make recommendations for changes in policy and procedure to the Commission on Education and Manpower.

Executive Director of CME

This individual should be housed at the Headquarters of MSMA and be administratively responsible to the Executive Director of MSMA. He should have the responsibility of administering the CME program of MSMA. He should attend all meetings of the Committee on CME, make regular visits to the Councilor District Representatives, assist in the preparation and presentation of annual budgets, administer the preparation and distribution of printed material, collate and prepare reports received from the District CME Representatives and the County Medical Societies relating to CME. He should keep the Commission on CME and Manpower and the Executive Director informed on all CME activities.

Commission on CME and Manpower

As a part of its usual duties, this commission should review the activities of CME on a statewide level and make recommendations on policy to the Council of the MSMA. It should prepare and submit regular reports to the Council. The Commission should function as a liaison to the various educational institutions, e.g., the medical schools, teaching hospitals, specialty organizations, etc.

County Medical Societies

The County Medical Society would request that each member submit, at some regular intervals, a diary of his continuing education activity. The Society would collect and submit their reports to the CME district representative, who would submit them to the Executive Director of CME. The Commission on CME and Manpower would review the reports and made recommendations to the Council for any awards that are felt to have been earned.

Interspecialty Commission

The professional societies which have delegates to the Interspecialty Commission would be asked to identify the quantity and quality of education needed by their membership. Each specialty group would develop guidelines for CME of its membership. These guidelines should reflect national standards and be consistent with AMA standards as expressed in "Essentials for Continuing Medical Education." The societies would suggest criteria for accrediting educational institutions which provide CME programming.

The following is an expense budget proposal:

CME representative travel and communication—$500 × 10 =	$ 5,000
MSMA Director of CME (part-time)	7,500
MSMA Secretarial support (part-time)	2,500
MSMA Travel and communication	2,500
Printing	500
Consultation	1,000
Committee Expense	750
	$19,750

Suggested sources:

1. Foundations, grants
2. Membership assessment
3. MSMA reallocation

REPORT OF THE AD HOC COMMITTEE 116th ANNUAL SESSION

For the third year in succession, the Committee invited the respective medical specialties to sponsor and develop Scientific Sessions of their own choosing to be included in the MSMA 116th Annual Session, April 4-7, 1974, Kansas City. The Committee is pleased to report the response was very gratifying. A total of twenty-five 90-minute sessions were developed and will be presented, including one General Session and two programs presented by voluntary agencies.

The Program Committee also invited the medical specialties to schedule their business and social functions during the MSMA Annual Session. Again, the response was good.

The Committee would like to express appreciation to the official representatives serving on the MSMA Commission on Interspecialty Medicine for their cooperation and interest.

George H. Ladyman, Chairman
Andrew McCanse
Richard J. Dames
William C. Allen
W. Wayne Boydston
Paul R. Young
W. Thomas Morgan, Jr.
John M. Laird, Jr.

(Referred to the Reference Committee on Medical Education and Public Welfare.)

REPORT OF COMMISSION ON MEDICAL-LEGAL AFFAIRS

In February of 1971, President Nixon directed the Secretary of HEW to convene a Commission on Medical Malpractice to undertake an intensive program of research and analysis in this area. Dr. Fritz Taylor, an attorney and anesthesiologist from Kansas City, served on the Commission staff and presented to our Commission a most interesting discussion on the background, the work and the final report of the Federal Commission.

Dr. Clark studied and summarized four proposals developed by various brokers for a group professional liability insurance program for MSMA members.

Our Commission recommended to the MSMA Council that an attorney be obtained to evaluate the Missouri malpractice situation, to determine a solution and to conduct a feasibility study of a group professional liability program.

At a preliminary meeting with an attorney from Arizona, it was determined that a desirable group plan should include:

1. Centralized claims handling.
2. Centralized coordination of legal defense.
3. Peer Review at county medical association level providing medical expertise.
4. Self-rating program based on loss experience.
5. Review of eligibility, renewal and termination of all insured and new applicants by the medical association. Carrier underwriter given final say in all cases.
6. Complete financial disclosure as to rates, claims and reserves.
7. Active defense of all nonmeritorious claims by the Association.

A proposal from this attorney for a feasibility study was presented to the MSMA Council. There was a large fiscal note on this proposal and it was felt by the Council that funds were not available at the present time to implement this plan.

Frederick J. McCoy, Chairman
David W. Brown
Francis X. Paletta
Bernard Draper
Robert L. Wilcoxon
Lee T. Ford, Jr.
Robert V. Tompson
Wilbur P. McDonald
Harold B. Rapp
William R. McPhee
Joseph S. Cope
Jerome I. Simon
Irving H. Clark
Jack R. Eidelman
George P. Wilson

(Referred to the Reference Committee on Constitution and Bylaws.)

REPORT OF THE COMMISSION ON INTERSPECIALTY MEDICINE

(This includes all reports of ad hoc committees set up under this Commission.)

During the preceding year, the Commission Chairman has attended meetings of the Ad Hoc Committee on Continuing Medical Education and kept Commission members apprised of these activities. Specialty representatives have referred to their respective organizations for advice as to their willingness to participate in formulating Specialty Continuing Medical Education Programs for MSMA. Affirmative responses to date were received from the following specialties:

> Allergy, Internal Medicine, Neurological Surgeons, Obstetrics-Gynecology, Otolaryngology, Pathology, Pediatrics, Surgery, Radiology.

Medical specialties have been polled for their sponsorship of one or more sessions at the 1974 State Meeting. The following specialty groups are sponsoring at least one 90-minute session and some as many as five 90-minute sessions at the 116th Annual MSMA Session, 1974:

> Allergy, Anesthesiology, Dermatology, Internal Medicine, Ophthalmology, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry, Radiology, Surgery, Urology.

Cyril Costello, Chairman
Herbert E. Rosenbaum
Truman Schertz
Hugh R. Waters
Francis X. Lieb
William S. Coxe
James W. Willoughby
Norman Asel
Edwin Bowe
Robert W. Allen
William Walker
G. Lynn Krause
Robert M. Hazen
Henry C. Allen
George J. Lytton
George P. Wilson
Larry G. Markel
Charles Roper

(Referred to the Reference Committee on Miscellaneous Affairs.)

THE COUNCIL

The Speaker stated that the portions of the reports of Council Meetings which are referred to Reference Committees are preceded by a black square (■) and are concluded with the committee assignment, which is set in bold face type.

Meeting of April 1, 1973

■ E. A. Stricker, M.D., St. James, President, called the meeting to order. Those present were Drs. Stricker; Walter T. Gunn, St. Louis; James C. Cope, Columbia; Gerald L. Miller, Kansas City; John I. Matthews, Jefferson City; Donald Judd, St. Louis; Robert A. Slickman, Kansas City; R. Allen Chandler, Kansas City; Max S. Franklin, St. Louis; John N. Martin, St. Joseph; Lysle M. Bach, Hannibal; Louis P. Hetlage, Troy; Robert E. Bregant, Jefferson City; William D. Bradshaw, Clinton; Howard J. McAlhany, Springfield; Claude W. Cooper, Thayer; Eugene T. Hansbrough, Poplar Bluff; William C. Allen, Columbia; Messrs. Lee Mortenson, Chicago, Ill.; John Noble, Kennett; Tom Papreck, Columbia; Allen D. Smith and Roger Weis, Kansas City; Hollister Smith, St. Louis; Ray McIntyre, Royal O. Cooper and C. C. Swarens, Jefferson City, Staff.

Dr. Stricker opened the meeting and introduced the new Councilor from the 5th District, Dr. Robert E. Bregant of Jefferson City.

Dr. Miller thanked the Councilors, Officers and staffs for their cooperation and for the privilege of working with them during his tenure in the various offices.

Dr. R. Allen Chandler was nominated and elected Chairman of the Council by unanimous vote and, thereby, became the presiding officer.

Dr. Max S. Franklin was elected Vice-Chairman of the Council. Dr. Donald Judd was elected Treasurer and Dr. John I. Matthews was elected Secretary.

The next meeting of the Council will be held on June 2-3, 1973, at the Ramada Inn, Jefferson City.

Dr. Chandler then made the following appointments to the Finance and Budget Committee, indicating that this would now be one committee: Drs. Judd, Chairman; Stricker; McAlhany; Cope; and Chandler.—**Referred to Reference Committee on Reports of Officers.**

■ Dr. Hetlage said that he wished to introduce several resolutions at this time. He moved that the following resolution entitled "Increased Socioeconomic Activity by the AMA Officers and Board of Trustees" be adopted. This motion was seconded and carried.

Whereas, The practice of medicine is beset at this point in history by a multitude of socioeconomic problems, and

Whereas, The American Medical Association, as the national body of Medicine, properly should represent the profession on a national basis in the resolution of these problems, and

Whereas, It is the desire of the members of the Missouri State Medical Association to be so represented, therefore be it

Resolved, That the Council of the Missouri State Medical Association calls upon the officers and Board of the American Medical Association to adopt a continuing "hard line" in dealing with those outside influences which are disruptive to the harmony of the profession and which are producing socioeconomic problems for the individual practitioner, and be it further

Resolved, That this resolution be carried by our AMA Delegation to the June, 1973 session of the American Medical Association House of Delegates for their further implementation.

Dr. Hetlage then introduced a resolution regarding the composition of the Missouri Mental Health Commission. A bill presently in the General Assembly seeks to change the present composition of the Commission. Dr. Hetlage moved that the following resolution be adopted. Motion was seconded and carried.

Whereas, A bill has been introduced to change the composition of the Missouri State Mental Health Commission from four physicians and three laymen to three physicians and six laymen, and

Whereas, The orientations for diagnosis, treatment and comprehension of psychiatric cases and problems should be primarily medical, and

Whereas, Input by laymen is desirable, therefore be it

Resolved, That the Councilors of the MSMA recommend that the composition of the Missouri State Mental Health Commission be preserved as is, and be it further

Resolved, That this resolution be forwarded to the members of the Missouri General Assembly.

Dr. Hetlage indicated that he had a third resolution, but did not have copies of it. He suggested that he would send copies to the Council prior to the next Council meeting and would like for this resolution to be tabled until that time. He stated that this resolution regarded the possible appointment of a special ad hoc committee to study the constitutional structure of MSMA in comparison to those constitutions of other states and to make recommendations to the standing committee on Constitution and Bylaws regarding changes.

Dr. Bradshaw said that he felt that a courtesy resolution should be introduced in future House of Delegates meetings regarding the attendance of whatever AMA representative is present, thanking them for their attendance. It was suggested that Dr. Sammons be sent a letter expressing appreciation of his presence at the 115th Annual Session of MSMA.—**Referred to Reference Committee on Resolutions.**

COMMITTEE TO STUDY PRIMARY PATIENT CARE

■ Dr. Bradshaw said that the committee to study the feasibility of additional training of physicians in primary patient care had met, and he submitted a committee report for education only. He stated that they had no recommendations to make at this time. He indicated that he would like to expand the size of the committee and continue to study this problem. He asked each Councilor to submit a name of a physician from his district who might be interested in serving on this committee.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORT OF MEMBERSHIP COMMITTEE

■ Dr. Martin reported on activities of the membership committee and indicated that he would like to keep the same members on this committee and add Dr. Hetlage and Dr. Judd. Dr. Martin presented four resolutions regarding a membership drive and recruitment, which were seconded and passed by the Council. These resolutions are as follows:

FURTHER MEMBERSHIP DRIVE STUDY

Resolved, That the newly appointed membership committee study the costs and specific means of implementing the following membership programs and report back to this Council at its June, 1973 meeting, with recommendations for action on:

1. A slide and script "road show" for use by Councilors at county meetings on the benefits of AMA-MSMA membership.
2. A year-end mailing to nonmembers from members of their specialty society urging their joining.
3. A year-end mailing to nonmembers by members of their hospital staff.
4. A one-day practice management clinic, discussing organized medicine, in cooperation with the appropriate institutions, and be it

Resolved, That this committee continue its studies on all six areas of membership recruitment and report to this Council on its findings as they progress.

PAC EDUCATIONAL FUNDING AND PAC NEWSLETTER

Whereas, The MSMA House of Delegates recently approved the transfer of MSMA dollars to MMPAC for educational purposes, and

Whereas, Less than 50% of MSMA members are MMPAC-AMPAC members, therefore be it

Resolved, That newly formed Membership Committee, in cooperation with the MMPAC Board, study and make specific recommendations on the costs and implementation of the following and report to this Council at the June, 1973 Council meeting:

1. A regular and separate MMPAC newsletter.
2. A separate PAC brochure on PAC benefits and plans for distribution to nonmembers in conjunction with a separate billing to nonmembers.
3. A PAC workshop this fall on PAC key-man programs and next year's political contests.

INTERN & RESIDENT RECRUITMENT DRIVE

Whereas, Interns and residents are the future of organized medicine and the medical profession, and

Whereas, Many interns and residents do not realize that organized medicine is open to them, therefore be it

Resolved, That MSMA, in cooperation with the AMA regional office, immediately undertake the following actions from the state office:

1. Send a welcome letter with an invitation to join their local society and direct responses to the appropriate local societies.
2. Work with those component societies in the area of medical schools to undertake a "person-to-person" campaign.

IMMEDIATE MEMBERSHIP DRIVE

Whereas, The number of Missouri members in the AMA has recently decreased, and

Whereas, The percentage of physicians in Missouri is decreasing and

Whereas, There is an immediate and compelling need for MSMA to begin a 1973 membership recruitment drive, therefore be it

Resolved, That the staff of MSMA, in cooperation with the AMA Regional Office, immediately undertake the following actions from the state office:

1. Send "thank you" notes to new and renewing members.
2. Send a letter to all physicians who have not renewed AMA or MSMA membership by July 1 of every year, requesting that they reconsider.
3. Undertake a statewide "person-to-person" membership solicitation program, directly to rural counties and in cooperation with large metropolitan counties as suggested in the Membership Committee's report.
4. Develop a basic combination AMA-MSMA benefits brochure for distribution to non-renewing and new nonmembers.

—**Referred to Reference Committee on Reports of Officers.**

■ Dr. Bradshaw asked what the position of the Guild presently is, and what will be the activity of the Ad Hoc Committee who worked on this, if any, due to the action of the House of Delegates regarding the Guild. The Chairman asked Legal Counsel to present the Council with a status report at the next meeting.—**Referred to Reference Committee on Resolutions.**

■ Mr. McIntyre indicated that previously, resolutions had been passed authorizing three individuals to sign checks from both main bank accounts at Mercantile Trust Company—our regular checking account and the new building fund. He proposed that the resolutions which had been passed be passed again with three names authorized to sign checks on the two different accounts. Motion was made, seconded and passed that Dr. Stricker, Dr. Judd and Mr. McIntyre be so authorized. Mr. McIntyre said that all three are bonded.—**Referred to Reference Committee on Reports of Officers.**

■ Dr. Hetlage brought up the matter of the insurance that the Association carries on the Council, Officers, Commission and Committee members when on official business. He asked whether or not this insurance is in force if he, as a Councilor, attends a meeting in Jefferson County. It was stated that, possibly, this should be clarified. The Chairman asked the Executive Secretary to include this in his report at the next Council meeting.

The meeting was adjourned.—**Referred to Reference Committee on Constitution and Bylaws.**

Meeting of June 2-3, 1973

■ R. Allen Chandler, M.D., Kansas City, Chairman, called the meeting to order. Those present were Drs. Chandler; E. A. Stricker, St. James; John I. Matthews, Jefferson City; Donald Judd, St. Louis; James C. Cope, Columbia; Walter T. Gunn, St. Louis; John N. Martin, St. Joseph; Lysle M. Bach, Hannibal; Max S. Franklin, St. Louis; Louis P. Hetlage, Troy; Robert Bregant, Jefferson City; Howard J. McAlhany, Springfield; Claude W. Cooper, Thayer; E. T. Hansbrough, Poplar Bluff; Stanley S. Peterson, Springfield; J. Loren Washburn, Versailles; Hector W. Benoit, Jr., Kansas City; Joseph V. Finnegan, St. Louis; William D. Mayer and William C. Allen, Columbia; Samuel B. Guze, St. Louis; George E. Thoma, St. Louis; R. K. Noback, Kansas City; Herbert R. Domke, Jefferson City; William L. Donegan, Columbia; Mrs. Charles Willman, St. Joseph; Mrs. George Lytton, Kansas City; Mrs. Terry Watson, St. Louis; Messrs. John Noble, Kennett; Lee Mortenson, Chicago, Ill.; Hollister S. Smith, St. Louis; Allen D. Smith, Kansas City; E. Mark Halvorson, Jefferson City; Ray McIntyre, Tom P. Fox, Royal O. Cooper, C. C. Swarens, Staff.

Dr. Chandler called the meeting to order and requested approval of the minutes of the April 1, 1973 Council Minutes. On motion, duly seconded, the Council Minutes were approved as distributed.

REPORT OF THE EXECUTIVE SECRETARY

Mr. McIntyre read thank you notes from Mrs. Thomas for the retirement gifts recently presented to her; from Mrs. Keith D. Jones expressing appreciation to the Council and Officers for their cooperation during her year as President of the Auxiliary; and from SAMA for renewing MSMA's sustaining membership. He also read a letter from the Missouri State Surgical Society expressing their appreciation for the fine cooperation from the MSMA. Dr. M. Pinson Neal also sent a letter of appreciation for the resolution which was passed in his behalf at the 1973 Annual Session.

Mr. McIntyre stated that the MSMA is presently sending the *AMA Newsletter* to key physicians in Missouri hospitals and asked the Council whether or not this should be continued. On motion, duly seconded, the Council agreed that this practice should be continued. —**Referred to Reference Committee on Reports of Officers.**

■ Mr. McIntyre stated that Dr. Bradshaw had previously asked each Councilor to name a physician in his respective district to his Primary Care Committee. These names should be sent to the State Office or directly to Dr. Bradshaw.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Dr. Benoit has been proposed by the AMA Board of Trustees as a candidate for the Council on Medical Service. Dr. Benoit has served a one-year term on this Council and is up for reelection. MSMA has sent a telegram to Dr. Howard endorsing Dr. Benoit for this post and a number of contacts with state delegations have been made in his behalf.

It was stated that unless there were an objection from the Council, the MSMA would retain membership in the Organization of State Medical Association Presidents. The annual dues are $50.—**Referred to Reference Committee on Reports of Officers.**

■ Mr. McIntyre indicated that a copy of a resolution on PSRO passed by the Georgia House of Delegates was included in the Council folders and said there will be much more discussion on this issue.

The MSMA 1973 House of Delegates passed a resolution regarding a commemorative stamp honoring Dr. William Beaumont. This information was sent to the U. S. Postal Department. The MSMA has been informed

The Annual President's Banquet

(Right) The Honorable Christopher S. Bond, Governor of Missouri *(center)* visits with many MSMA friends before the Annual President's Banquet on April 6. Governor Bond was guest speaker at the banquet which was attended by 470 members of the Missouri State Medical Association, the Woman's Auxiliary and their friends.

President James C. Cope *(right)* presents the MSMA aque of appreciation to retiring President E. A. Stricker.

As retiring President, Dr. Stricker *(left)* gives the historical MSMA presidential gavel to Dr. Cope, President for 1974-1975.

Twelve Past-Presidents of the MSMA were honored at e Banquet. *(First row, left to right)* Drs. Gerald L. iller, Kansas City; Paul R. Whitener, St. Ann; H. E. etersen, St. Joseph; Robert Mueller, St. Louis; James R. cVay, Kansas City; and Guy Magness, University City. *(Second row, left to right)* Drs. Joseph L. Fisher, St. Joseph; Kenneth C. Hollweg, Kansas City; Victor B. Buhler, Kansas City. David N. Kerr, Clayton; Doyle C. McCraw, Bolivar; Byron M. Stuart, Boonville; and E. A. Stricker, St. James (retiring President).

that such a commemorative stamp is not possible at this time, but our request will be held for future consideration.

Mr. McIntyre stated that the 1973 House of Delegates passed a statement endorsing the Health Care Foundation of Missouri to be the responsible agency for PSRO activities in Missouri. A letter was sent to Dr. William Bauer, Director, Office of PSRO, informing him of this action. Mr. McIntyre read the letter of reply from Dr. Bauer.—**Referred to Reference Committee on Resolutions.**

■ Clarification of insurance coverage for Councilors and Officers while on official business had been requested. Mr. Fox researched this matter and stated that Councilors and Officers are covered under our present insurance policy when on official business as a Councilor.—**Referred to Reference Committee on Constitution and Bylaws.**

■ Mr. McIntyre said that we have cosponsored the Mini-Estes Conference for the past two years. The Regional Medical Program has been the coordinator of these conferences. Attendance this year was about 100 less than the previous year. It has been suggested by the Missouri Hospital Association that this conference be discontinued at least for one year and, possibly, be resumed again the following year. Dr. Bowles, Chairman of the MSMA Commission on Public Affairs, concurs that this conference should definitely be postponed, if not completely discontinued. Mr. McIntyre asked for the Council's opinion in this regard. On motion, duly seconded, it was agreed that the Mini-Estes Conference should be discontinued for the present time.—**Referred to Reference Committee on Miscellaneous Affairs.**

REPORTS OF DISTRICT COUNCILORS

■ *District #1*—Dr. Martin indicated that Sisters' Hospital in St. Joseph is under reorganization and a Board has been formed to take over the operation of this hospital in November. The Board is made up of 21 lay people and two doctors. He indicated that there are many problems involved.

They are having their usual problems with CHP, but stated he felt physicians should definitely get involved in CHP activities so that they know what is going on and can help make policy and direct activities.

District #2—Dr. Bach reported that several new physicians have recently located in his area. He further stated that at his Councilor District meeting held in March, concern was expressed regarding PSRO.

District #4—Dr. Hetlage thanked the Council for implementing some of the suggestions of the fourth District and stated that, at this time, members in his district did not feel that they would make any further proposals.

District #5—Dr. Bregant stated that PSRO is the main concern in his district at the present time.

District #8—Dr. McAlhany indicated that Dr. Bonebrake's insurance committee is looking over life, overhead and major medical insurance and, hopefully, will be able to pursue this matter and make recommendations to the Council for the development of a statewide program. Both St. Louis Medical Society and Jackson County Medical Society have recently changed their programs. This insurance committee will continue its study.

Dr. Grebel spoke to the Greene County Medical Society regarding the Health Care Foundation and did a very commendable job.

Dr. McAlhany reported that in April, the Court of Appeals upheld the IRS tax decision in favor of the "Singing Doctors."

District #9—Dr. Cooper indicated that in his area, there are a few physicians who do not belong to any organization such as the local society, etc. They are trying to get these physicians involved in organized medicine. There are a number of concerns in his district regarding PSRO and still a few complaints about the manner in which Medicaid and Medicare handle their claims.

District #10—Dr. Hansbrough indicated that he recently spent a night at Crown Center Hotel in Kansas City where the MSMA 1974 Annual Meeting will be held and thought it was very nice.

District #3—Dr. Franklin said they had a ballot opinion of their membership regarding the building of new facilities to house both the St. Louis Medical Society and the St. Louis County Medical Society. About 50% of the membership returned their ballots and the vote was 57% to stay and 43% to move. For the St. Louis County Society, the vote was about 50% each way. Further meetings will be held in this regard.—**Referred to Reference Committee on Reports of Officers.**

■ Dr. Franklin stated that he had received a letter from Blue Shield regarding its Open Panel Program. Along with this letter of invitation to be a sponsor of the plan was literature which they plan to include in their selling program. Included in this selling material was the resolution from MSMA supporting the Open Panel Program. Dr. Franklin indicated that he did not feel this was truly an open panel program and read his letter of reply to Blue Shield.

Dr. Franklin stated that he received the new, revised Bylaws of the Health Care Foundation. He said that in Subsection 5, he interpreted one part as giving the Judicial Committee the authority to suspend or expel members in the MSMA or the MAOPS. Dr. Benoit stated that this was a misinterpretation; the HCF definitely has no control over membership in either organization and has no such intention. The wording of this will be changed to make the meaning clear.

The St. Louis Medical Society has produced a Handbook on Health Careers and also a Reference Book for Physicians.

Dr. Hetlage explained that the Blue Shield Open Panel Program was developed over a year and a half period of time with much physician input. He stated that he doubted that the MSMA resolution would be used in their advertising.

Dr. Franklin said he has discussed this open panel program with many St. Louis physicians, and it seemed that most OB's and Surgeons were for it and many GP's and internists were against it.—**Referred to Reference Committee on Resolutions.**

■ *District #7*—Dr. Chandler reported that Dr. Hoffman, President of the AMA, will attend an informal dinner meeting at the Plaza III in Kansas City on June 14. He invited those in the area to attend.

Dr. Chandler stated that a PSRO Study Committee has been formed in Jackson County and is made up of members of the Jackson County Medical Society Blue Shield, Hospital Association, HCF and Osteopathic Association.

The Chairman indicated that he had received many suggestions from the Council on how the Council Meetings should be conducted, etc. and asked the Council to think about having an informal session on Friday evening prior to the Council Meeting to go over some of the material so that the Saturday sessions could be more concise with less discussion.

Dr. Chandler also asked the Council to think about taking advantage of some of the programs offered by the

AMA, such as a leadership conference for which the Council might select a small group of young, promising physicians in their respective areas, these people to be the captive audience. The AMA has experts in these fields. The only cost to the MSMA would be for the motel and the food.

Dr. Chandler said that another thing to think about is an MSMA Goals Committee patterned after the Battelle Report made for the AMA on goals of the future.

REPORT OF TOUR COMMITTEE

The Chairman then named the following Councilors to a Tour Committee to work with Royal Cooper on suggested upcoming tours to be sponsored by MSMA: Drs. Cooper, Martin and Bregant.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF MSMA LEGAL COUNSEL

■ At the previous Council Meeting, Legal Counsel was asked for an opinion concerning the present status of the Ad Hoc Committee on the Negotiation of Professional Fees in view of the House of Delegates action on the Guild proposal.

Mr. Noble reported on this, giving background information regarding the Committee, the House action, etc. He stated that it would appear that the special Ad Hoc Committee ceased to exist upon its report of January 17, 1973 to the Commission on Medical Economics, Third Party Medicine and Governmental Relations.

Mr. Noble reported that the transcript in the Health Care Foundation Law Suit has been filed. This case will be set for hearing during the week of Jan. 7, 1974. After a case is set for hearing, the appellant's brief is due some 90 days before the date of hearing and the respondent has an additional 30 or 60 days to file a reply.

After brief discussion, motion was made, seconded and carried that the report of the Legal Counsel be accepted. **—Referred to Reference Committee on Resolutions.**

REPORT OF THE PRESIDENT

■ President Stricker made the following appointments of Councilor Advisors to the various Commissions: Commission on Public Affairs—Dr. Bradshaw; Commission on Continuing Education and Health Manpower—Dr. Hansbrough; Commission on Medical Economics—Dr. Hetlage; Commission on Medical-Legal Affairs—Dr. McAlhany; and Commission on Interspecialty Medicine—Dr. Cooper.—**Referred to Reference Committee on Reports of Officers.**

■ One of the resolutions adopted by the 1973 House of Delegates called for a Committee to Study Midwifery. Dr. Stricker made the following appointments to that committee: Drs. William Griffin, Columbia, Chairman; Harry Jonas, Independence; Denis Cavanagh, St. Louis; Henry C. Willumsen, St. Joseph; and W. Alexander Hoja, Poplar Bluff.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ Dr. Stricker indicated that he and Drs. Benoit, Cope, Richard Bradley and Mr. McIntyre attended a meeting called by the AMA in Washington. Thirty-six states were represented. This meeting was concerned with the appropriate areas for PSRO. The Missouri delegation was unable to obtain appointments with Senator Eagleton and Congressman Symington. However, they did have an opportunity to discuss certain matters with their Legislative Aides. Dr. Stricker indicated that Dr. Benoit would discuss this further.

Dr. Cope reported that he had had the pleasure of attending Alumni Day at Central Methodist College on April 28. Dr. William Bailey, a St. Louis ophthalmologist, and Dr. Robert Hodge, a Kansas City internist, were presented Distinguished Alumni Awards. Also receiving this Distinguished Alumni Award was Ray McIntyre. Dr. Cope extended his congratulations to Mr. McIntyre and read the following biographical information on his many accomplishments:

"Noted Executive Secretary of the Missouri State Medical Association and a veteran of more than 30 years in the health care field.

"Raymond R. McIntyre, class of 1932, was born in Holt County, Missouri. During his high school years, he was active in many school organizations and played on Oregon's state championship basketball team.

"During his years at Central, Mr. McIntyre was a four-year member of the 'C' Club, winning letters in both basketball and football. He played on Central's basketball conference championship teams all four years, was quarterback of the football team and captain of the basketball team. In addition he was a student body officer, member of the Aristotelian Literary Society, Theta Chi Delta, Delta Phi Alpha and a 'Campus Leader.'

"Mr. McIntyre returned to CMC in the spring of 1935 as assistant enrollment secretary to E. E. Rich, following three years of teaching in Montgomery City and Macon. He also was assistant basketball coach under C. A. Clingenpeel and received his master's degree in education from the University of Missouri during this time.

"He was principal and basketball coach at Fayette High School for two years, returning in 1941 to the University of Missouri as a doctoral candidate in education during the fall semester and assisting the enrollment secretary in the spring semester. He continued his interest in basketball, playing on semiprofessional and independent teams and officiating at high school games.

"In 1942, Mr. McIntyre joined the staff of the Missouri State Medical Association in the St. Louis offices. From 1944 to 1946, he served in the United States Naval Reserve, holding at his release the rank of Lieutenant and administrative assistant to the commanding officer of Barin Field, Pensacola, Fla.

"Returning to the State Medical Association as field secretary, he worked with doctor placement, county medical societies and the Missouri State Medical Foundation. He was instrumental in organizing the Missouri Health Council and served as its president. He also served as executive secretary for the Missouri Academy of General Practice.

"In 1965, Mr. McIntyre became executive secretary of the Missouri State Medical Association, and in 1966 directed the transference of the offices to Jefferson City, where he now lives.

"Mr. McIntyre has been awarded the Distinguished Service Award of the Missouri Academy of General Practice and was elected an associate member of the Southern Medical Association. He holds an affiliate membership in the American Medical Association and is a member of the American Association of Medical Society Executives.

"Mr. McIntyre was married in 1938 to the former Martha Donaldson, then a women's physical education instructor at CMC. They have two daughters and five grandchildren. Mr. McIntyre is a member of the Chamber of Commerce in Jefferson City, the Rotary Club and the United Methodist Church."—**Referred to Reference Committee on Reports of Officers.**

REMARKS OF DR. BENOIT RE: HCF AND PSRO

■ Dr. Benoit gave a brief account of what took place at the most recent Board Meeting of the Health Care Foundation. He stated that the MSMA has given the HCF endorsement as being the PSRO agency in Missouri and that a similar action was taken by the MAOPS. He said that this should be of help in their ongoing efforts.

He said that the Council had been circularized with a set of revised Bylaws for HCF. Sixteen were returned; 14 without comment. One of the comments was Dr. Franklin's in regard to Subsection 5, and the other was relative to the appointment of chairmen of local review committees. The Bylaws stated that the Central Coordinating Committee would have this responsibility, and the suggestion made was that each review committee should have the prerogative of electing its own chairman. These changes were made and the new Bylaws have gone into effect. Dr. Benoit indicated that the funding situation for HCF is in a critical state. The EMCRO grant was denied. RMP has been giving a nominal fee to HCF monthly, but it is felt this would terminate due to the RMP funding situation. Another solicitation letter is being sent out. However, we cannot determine as yet what the response will be.

He said that time had been spent with Dr. Domke in relation to the computer program in the Division of Health on hospital discharge summaries. The HCF has gone on record as being in favor of further study of this matter.

Another major item discussed by the Board was a draft of a concept for delivery of services for PSRO through the HCF. It is the intention of the Foundation to develop this so that if and when in dealings with Dr. Bauer there is discussion as to whether or not the HCF would qualify, this can be used.

Dr. Benoit gave background information regarding how the meeting in Washington on PSRO came about. Several of the larger states were concerned about the geographical distribution. They requested an informal confrontation with HEW. The AMA arranged this meeting and invited all the states. The AMA provided everyone who came to the meeting with a kit of information which capsulized what the facts were as they related to the development of local PSRO's. There were certain good reasons for having an umbrella PSRO. Dr. Benoit said that his reaction was that an overwhelming percentage of Senators and Congressmen who voted on this legislation had no real insight as to what they were voting on. There is nothing in the law that states the number of physicians, minimum or maximum, for a PSRO. It was the feeling that certain staff people with the U. S. Senate are making the decisions as to the intent of the law.

Most of the delegations at the Washington meeting did see their elected officials or their legislative aides to indicate to them that medicine's views on PSRO should be given attention and informational material was left with them. After looking at the material and at the law, it is hoped that they would be willing to contact HEW Secretary Weinberger. Dr. Benoit stated that he felt more formal trips to Washington by representatives of MSMA with better preparation, to the extent of having luncheons and meetings with the Missouri elected officials, should be looked at more than in the past.

Dr. Benoit, as a member of the AMA Council on Medical Service, reported on the activities of that Council. The Council had a meeting in Washington with people from the Bureau of Health Insurance and went over such problems as reimbursements under Medicare and Medicaid; the role which they visualize the physician assistant has; etc. Another matter discussed quite extensively has to do with including all people on dialysis under Medicare. A lot of the input that the Bureau of Health Insurance had on this matter was from an ad hoc committee of the National Kidney Foundation. We reviewed some of the reports having to do with this program. The Council on Medical Service took strong exception to the per capitation concept with the basic philosophy being that what is really different in chronic renal dialysis than other diseases such as diabetes, arthritis, etc. The Bureau of Health Insurance would have the sole power to certify and recertify the centers. Any patient not considered as a potential transplant candidate could not be on the program. The program called for extremely elaborate review mechanisms on a local, regional and national basis. Appropriate letters were sent to BHI and Secretary Weinberger regarding this proposal.

Lengthy discussion followed in regard to Dr. Benoit's report. Many questions arose regarding the Health Care Foundation and PSRO. Dr. Benoit stated that a hospital will not qualify as a PSRO, no matter how large it is. He stated that his personal goals for the HCF regarding PSRO would be for the HCF to act as an umbrella organization and become the contracting agency with HEW to see that PSRO is done right in Missouri. He feels that the local review areas of HCF should be able to qualify as separate PSROs. Dr. Benoit stated that there would be a State Advisory Council to serve as a second step between what goes on in a local PSRO and the National Advisory Council. No PSRO will be approved unless at least 50% of the physicians in the area agree to it. However, the review process will be 100%.

Dr. Benoit then called attention to Intermediary Letter #10 which calls for establishment of preadmission certification on all beneficiaries under SSA Health Care Programs in every hospital in the country by July 1, 1973. He said that he was told that this is only an advance copy and was directed to the Regional Offices for discussion.

Dr. Benoit said that the Health Care Foundation is writing every member of the Missouri delegation in Congress, pointing out what the PSRO law calls for, what the problems are and what the HCF has to offer to try to implement the law.

It was suggested that along with the legislators being educated, the MSMA should be educating the physicians, since many aspects of this law are not clear to them.

Mr. Mortenson indicated that a bulletin that came to the AMA Office just prior to the Council Meeting gave the names of the physicians appointed to the National Advisory Council on PSRO. He stated that at least four of these individuals are strong friends of organized medicine.

Dr. Cope pointed out that during the trip to Washington, they were assured that probably no regulations concerning PSRO would be forthcoming until after the program is well underway.

Dr. Chandler thanked Dr. Benoit for bringing the Council up to date on the various activities.—Referred to Reference Committee on Resolutions.

REPORT OF THE MISSOURI DIVISION OF HEALTH

■ Dr. Domke indicated that most of those present were acquainted with the "Icepick" Program of the Division of Health. He stated that the State Board of Health has taken the position that the Hospital Discharge Data Program should be a required activity and that the program should be carefully developed in cooperation with MSMA, MAOPS, HCF and the Hospital Association. Dr. Domke said that the Board of Health would like to get a system which will not lead to duplication or conflict with any other system being used. He stated there are demands for good hospital use data and this program can be developed to provide the information that users and providers need without having conflicting systems. He indicated that the Board would like to have providers and users participate in the design of the program. Dr. Domke said that presently, 80% of the hospitals and 65% of the discharges in the state in the program are on a voluntary basis. He stated that the hospital associations are eager to see a system that will avoid duplication and that the present "Icepick" Program probably is not sufficient for most hospitals and the medical profession. The only additional cost involved would be for providing the data on the face sheet of a chart. He indicated that we have a poor impression of what is going on in hospital utilization in the state, primarily because the "Icepick" Program has almost 100% participation in rural areas, but does not have good participation in the metropolitan areas.

Dr. Domke stated that the Board of Health was asking participation and review to see if we can have a single state system that would be satisfactory to providers as well as economical in getting the information out.

Mr. McIntyre asked that since this program would be made mandatory, if there would be any additional cost to hospitals in supplying this information. Dr. Domke stated that the present program is funded out of their general fund. Basically, the information required would be face sheet information and the Division of Health would provide forms if hospitals wanted them, but they would take the information in any form. Dr. Chandler stated that Dr. Domke had written a letter asking for the views of MSMA in regard to this program and he did not see that this required any action.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Dr. Domke reported that the bill deleting mandatory smallpox vaccination from state statutes had been sent to the Governor. He stated that Senate Bill #57, which calls for regulation of ambulances, is awaiting final passage.

Dr. Domke said that he would like to call the Council's attention to Senate Bill #103, which calls for a Division of Developmental Disabilities for the mentally retarded. The purposes would be to provide leadership in the planning, operation and evaluation of all programs for the developmentally disabled and to establish priorities and use funds to assure the orderly development of a statewide comprehensive network of services for them. He indicated that perhaps the bill should have attention from the Legislative Committee.

REPORT OF THE LEGISLATIVE COMMITTEE

Dr. Matthews presented a list of favorable Senate bills and Senate bills of interest that the Legislative Committee had been following. Dr. Matthews also presented a list of favorable House bills and House bills of interest to the Council. Dr. Matthews informed the Council that several House bills had been stricken from the calendar.

Dr. Matthews stated that Dr. Domke had brought up Senate Bill #103 and that the Committee will look into it further and try to get an opinion about the bill.

Dr. Matthews stated that he would like to extend congratulations to the staff who have worked hard and long this session because it looks as if this will be a most productive year.

Motion was made by Dr. Hetlage to accept this report with commendation. Motion was seconded and carried.—**Referred to Reference Committee on Miscellaneous Affairs.**

CANCER RESEARCH CENTER

■ Dr. William Donegan of the Cancer Research Center indicated that he appreciated the privilege of bringing before the Council the proposal by the Center for "Breast Cancer Detection Projects" and asked for MSMA approval and support.

This project is sponsored by the National American Cancer Society and the National Cancer Institute. Facilities will be established to provide a comprehensive screening examination for asymptomatic women at no cost to them using physical examination, mammography and thermography. Any individual with suspicious findings is referred to her family physician or a physician of her choice for definitive diagnosis and treatment. Dr. Donegan stated that an examination of this type can detect breast cancer early enough to effect a cure rate. He indicated that this type of examination has been tried before on a limited basis and seems to work.

Dr. Cope asked about the cost of the project. Dr. Donegan indicated that he was not sure as to the specific cost, but that it had been worked out at the National Cancer Institute. Dr. Stricker asked how often a woman should have one of these examinations. Dr. Donegan indicated it probably would be annually.

Motion was made by Dr. Hetlage to approve the program as outlined. The motion was seconded by Dr. Bach and carried.—**Referred to Reference Committee on Medical Education and Public Welfare.**

MATTERS REFERRED TO THE COUNCIL BY THE 1973 HOUSE OF DELEGATES

■ *Resolution regarding endorsement of American Physiological Society request for a Commemorative Stamp honoring William Beaumont, M.D.*—Dr. Chandler indicated that the necessary correspondence had been sent to the Postmaster General.—**Referred to Reference Committee on Resolutions.**

■ *Resolution regarding Bert Thomas*—Mr. McIntyre reported on this in the Executive Secretary's report.

Resolution regarding M. Pinson Neal, M.D.—Copy of resolution has been sent to Dr. Neal.—**Referred to Reference Committee on Reports of Officers.**

■ *Resolution #1—Emergency Medical Services*—Called for President of MSMA to appoint ad hoc committee to work with organizations in this area. Dr. Chandler reported that we have an Ad Hoc Committee on Emergency Medical Services under the Public Affairs Commission, appointed by the Chairman of that Commission, and he would like to recommend to the President, subject to Council approval, that this present committee be reappointed. This recommendation was given Council approval.

Resolution #5—Medicredit Legislation—Correspondence has been sent to Dr. Howard of the AMA and to our Congressmen.

Resolution #9—Health and Hospital Insurance for Newborn—The Chairman referred this to the Legislative Committee for study and recommendations.—**Referred to Committee on Miscellaneous Affairs.**

■ *Resolution #13—Speaker's Qualifications*—Mr. Noble pointed out that this would require a constitutional amendment. The Chairman referred this resolution to the Committee on Constitution and Bylaws.—**Referred to Reference Committee on Constitution and Bylaws.**

■ *Resolution #18—Insurance Claim Forms*—The Chairman reported that this resolution has been sent to HIC and to the AMA Council on Medical Service, but a reply has not been received from them.—**Referred to Reference Committee on Resolutions.**

■ *Resolution #19—Committee to Study Midwifery*—The Chairman indicated that a committee had been appointed.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ *Resolution #20—Funds for MMPAC, to be used for educational purposes only*—The Chairman indicated that this would be turned over to the Finance Committee to find a way to obtain the money.—**Referred to Reference Committee on Reports of Officers.**

■ *Resolution #22—Exclusion of Regional Medical Programs from the Federal Budget*—This resolution has been sent to the Missouri Congressional delegation.

Resolution #32—Regulation of Missouri Medical Service—The Chairman reported that a copy of the resolution has been sent to the Governor and to all members of the Missouri General Assembly.—**Referred to Reference Committee on Resolutions.**

■ *Resolution #33—Introduction of Resolutions*—Mr. Fox reported that this had been discussed at a joint meeting of the Commission on Continuing Education and Commission on Interspecialty Medicine as it would relate to the necessity of changing the time schedule for the Annual Session. He indicated that proposed time changes had been submitted to the joint meeting of the commissions. Mr. McIntyre reported that this had been discussed thoroughly and the entire group felt that without experiencing what might happen to the Annual Session time schedule, that, perhaps, it would be better to leave the time schedule as it is for another year. It was pointed out that a full Commission report would be given later in the meeting and that no decision or recommendation be made until that time.

Dr. Chandler stated that, perhaps, it would be a good idea to move the Council Meeting to 3 PM on Wednesday afternoon at the 1974 Annual Session. This had been suggested in the proposed time schedule given to the meeting of the joint Commissions.

Motion was made by Dr. Franklin that the Council Meeting on Wednesday afternoon of the Annual Session be moved to 3 PM. The motion was seconded and carried.

REPORT OF THE MEMBERSHIP COMMITTEE

Dr. Martin reported that the Membership Committee had met and the areas discussed were in three parts: (1) Projects for Immediate Implementation; (2) Study of Special Projects; and (3) MMPAC Educational Projects. Those items for immediate implementation are as follows: (1) Thank you letters to new and renewing members; (2) Letter urging reconsideration to physicians not renewing MSMA or AMA membership by July 1; (3) Statewide rural membership campaign from state level; (4) MSMA benefits brochure for present members, new members and nonrenewing members; (5) Welcome letter from state level to interns and residents, return would be to local societies; (6) Large component societies encouraged to undertake "person-to-person" campaign with I and R. This is being done in Kansas City and St. Louis, but, perhaps, the state might offer assistance to Boone County.

Special Projects included (1) Composition of a slide and script "road show" on MSMA/AMA benefits for use by Councilors at county meetings; (2) Year-end mailing to nonmembers by specialty society and hospital staff; (3) Implementation of practice-management workshop for interns, residents and students at schools and hospitals. MMPAC Educational Projects include: 1. Develop separate MMPAC Newsletter for educational purposes only; 2. Produce and distribute separate MMPAC Educational brochure; 3. Implement a viable MMPAC Educational Workshop for stressing voters' responsibility. Dr. Martin stated that this information was not sent out in advance to the Councilors and that, perhaps, they should look it over and discuss it later in the meeting.

REPORT OF THE WOMAN'S AUXILIARY

Mrs. Willman stated that she appreciated being invited to the meeting and that she would like to introduce Mrs. George Lytton of Kansas City, President-Elect of the Woman's Auxiliary.

Mrs. Willman reported that the Auxiliary held a Legislative Day on April 11 in Jefferson City. Approximately 100 women from 12 counties attended. Each county took their Senators and Representatives to lunch.

Mrs. Willman stated that she had visited in Hannibal and that the Auxiliary there had decided to again become active after having disbanded in 1965. She stated that she was glad to see the women in Hannibal become so interested.

Rally Day Workshops have been held covering nine districts. The Auxiliary has talked to approximately 300 doctors' wives about Auxiliary programs in order to better inform their members.

Mrs. Willman reported that the Auxiliary is planning an Ecology Seminar on September 21 in Kansas City. All County Presidents, Presidents-Elect and County Environmental Health Chairmen will be encouraged to attend. Mrs. Raymond Hartwig is working with the Environmental Protection Agency to provide funding. She encouraged all those present to attend.

Mrs. Willman stated that representatives from the Auxiliary would attend the following MSMA Committee meetings in order to better coordinate endeavors: Commission on Continuing Education and Health Manpower, Legislative Committee, Commission on Public Affairs, MMPAC and the Association's Medical Student Loan Foundation. She reported that she had given names to Dr. Chandler and that the Auxiliary would be glad to help in any way they could.

REPORT OF THE BUILDING COMMITTEE

Dr. Matthews reported that the staff had moved into the new building and are happily located. He stated that he hoped all of those present will tour the new building later in the afternoon. He indicated that they are still a few items that need to be installed, but that they are on order. Dr. Matthews stated that the overall arrangements and development of the building have been extremely satisfactory and hoped that everyone will like it.

Dr. Matthews reported that final details regarding financing have not been developed as yet. Final bills are about to be accumulated. Then, it will be the responsibility of the Finance Committee to handle the loan program.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF MISSOURI FAMILY PLANNING HEALTH COUNCIL

■ Dr. William Allen reported that he had represented MSMA at an organizational meeting of the Missouri Family Planning Health Council and that the MSMA has been requested to name a representative to serve on the Board of Directors of this Council. The purpose of the Council is to become the coordinating agency for family planning projects in outstate Missouri, but the Council would not affect metropolitan family planning projects.

Dr. Allen stated that the Family Planning Council in

MSMA Members Receive 50-Year Pins

Eleven MSMA members who have completed 50 years ı the practice of medicine attended the President's Ban-uet and were honored. *(First row, left to right)* Drs. Carl . Ferris, Kansas City; Nathan Bilsky, St. Louis; Fred K. Vilson, Winston; Marion A. Webb, Clayton; and Irwin S. Brown, Kansas City. *(Second row, left to right)* Drs. Wilber B. Spalding, Plattsburg; Burleigh E. DeTar, Joplin; Watkins A. Broyles, Bethany; William A. Fuson, Trenton; John H. Ryan, St. Joseph; and Paul R. Whitener, St. Ann.

Missouri had been urged by HEW to submit a state proposal for family planning. The Bylaws of this Council provide for a 24-member Board and call for representation from MSMA, MAOPS, Missouri Nurses Association and a physician to be appointed by the President of the Board. The latter also is to be Chairman of the Medical Advisory Committee. The Board will meet quarterly and the Council will meet twice yearly. A grant proposal of approximately $2 million, which has been submitted, would not cover the entire state immediately.

Dr. Allen stated that he felt that although the project proposal had been submitted and the Bylaws adopted, this group could use medical direction and urged MSMA to give serious consideration to appointing someone to serve on this Board. He also stated that he fully agreed with the four recommendations of the Ad Hoc Family Planning Committee which were presented to the Council in September. The recommendations are as follows:

1. Recommend that due to the divergence in nature of the clinics, local medical societies and/or local physicians be urged to take a more active role in the establishment and operation of family planning clinics.
2. Recommend frequent appraisal of each clinic's programs as to its continued effectiveness and in its respect for medical ethics.
3. Recommend frequent appraisal of the clinic's programs in such areas as number of patients reached and costs-per-patient.
4. Recommend frequent appraisal of the clinics as to the extent they are invading the private practice of medicine.

Dr. McAlhany asked if this program would void those now in existence. Dr. Allen stated that the programs now in existence would make application to this group rather than directly to Washington.

Dr. Hansbrough indicated that the MSMA should go on record as reminding that Board of our recommendations in these four fields. Dr. Chandler stated that the MSMA had been asked to appoint a member to the Board and that man can take these recommendations to the Board.

Dr. Domke stated that the Council recommendations are sensible and, at least, provide a minimal guide to evaluating a project. Dr. Domke stated that he would like to recommend that in addition to sending the information about Council action to that group, that we also forward it to the Governor's Advisory Council on Comprehensive Health Planning, A & B agencies and to the Board of Health. He stated that the recommendations are sound and would provide some basis for this. The Council also would be able to see that there is some statewide review of what these programs were accomplishing.

Motion was made, seconded and carried that these four points be sent to the Division of Health, A & B agencies and the Governor's Advisory Council on Comprehensive Health Planning and that MSMA appoint a member to the Board as requested by the Family Planning Health Council. Dr. Chandler asked Dr. Stricker to make the appointment.

Dr. Chandler stated that a request had been received from the AMA Council on Foods and Nutrition asking for MSMA endorsement and cosponsorship of a program of seminars and lectures on college campuses this fall. The program is to inform students and faculty of recent developments and to stimulate interest in the medical sciences. The colleges participating in Missouri are Central Missouri State, Drury College, Missouri Southern College, Northwest Missouri State, Northeast Missouri State and Southeast Missouri State College.

Motion was made by Dr. Gunn to give MSMA endorsement to this program. It was seconded by Dr. Hansbrough and carried.

Dr. Martin asked that Missouri Western in St. Joseph be added to the list of colleges.—**Referred to Reference Committee on Miscellaneous Affairs.**

MSMA-SPONSORED TOURS

■ Mr. Cooper reported that the Rhine Tour is selling exceptionally well. Approximately 140 persons have signed for the tour. Another mailing will be sent late in June.

Mr. Cooper indicated that a travel committee, consisting of Drs. Cooper, Bregant and Martin, had a meeting and that Dr. Cooper would make a report regarding future tours.

Dr. Cooper indicated that the committee had considered three tours as follows: Greek Tour, European Tour and a Hawaiian Tour.

Dr. Cooper moved that the three tours be accepted for MSMA in 1974. Motion was seconded and carried.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORTS OF THE DEANS

■ Dr. Mayer stated that he would like to present a follow-up report on several items that he presented previously. He indicated recommendations had been made to the Chancellor for names for the Provost for Health Affairs at the University.

Dr. Mayer reported that the University had a significant increase in the number of applicants for medical school. The University had 570 Missouri applicants last year and 700 applicants this year. Of the 700 applicants, 140 had been accepted by the University.

Another item he reported on was the University budget. Dr. Mayer stated that the University would be in trouble with operational dollars if the budget were not approved by the General Assembly. Dr. Mayer indicated that the report of the National Board of Medical Examiners had been released recently and that he could obtain copies for the members of the Council, if they so desire.

Dr. Mayer stated that he would like to comment in regard to HR #1. The law separates teaching hospitals and their physicians as totally separate from the rest of the practitioners. The SSA will be deciding whether teaching hospitals will be cost hospitals or usual and customary fee hospitals. There is a high likelihood that the University Hospital will be a cost hospital.

Dr. Mayer stated that he had the good fortune to be involved in some national medical activities and would be glad to be helpful in the communication processes at this level.

Dr. Noback reported that the Medical School in Kansas City had graduated nine students. All have taken part two of the National Boards and have passed. The family practice preceptorship program in Year 2 will start its second year in about a month. This program provides each Year 2 student a month with a family practitioner in Western Missouri.

Dr. Noback reported that the Kansas City Medical School has had a quarterly profile examination in existence for just over a year. One part deals with the evaluation of the students and the other part deals with factual information.

Dr. Noback stated that there has been increasing interest in the school on the part of students. This year they received just under 400 applicants from Missouri.—**Referred to Reference Committee on Medical Education and Public Welfare.**

TAP INSTITUTE

■ Mr. Fox, in the absence of Dr. Ladyman, reported on the TAP Institute which had been cosponsored by MSMA and the Hospital Association. Dr. George Ladyman, Chairman of the Commission on Continuing Education, represented the MSMA and gave the welcoming address at the first session. The program was presented by the Joint Commission on Accreditation and consisted basically of three sessions covering utilization review, medical audit, credentials, legal liability and administration. It was pointed out that it is evident that JCAH hopes to be involved in the administration of PSRO. Mr. Fox stated that two of the Councilors, Drs. Martin and Chandler, were present at the institute representing local medical society staffs and, perhaps, they would like to make a few comments.

Dr. Martin stated that the only comment he would like to make was that he was impressed with Mr. Jacobs from the JCAH, who conducted the program. Dr. Chandler stated that he was interested in the medical audit area of the program. He stated that General Hospital in Kansas City had been using this for some months, that it was very appealing and would be to all doctors since they set up their own criteria for such an internal audit.

Motion was made by Dr. Hansbrough that Dr. Ladyman's report be accepted with commendation. Motion was seconded and carried.

REPORT OF JOINT MEETING OF COMMISSIONS ON CONTINUING EDUCATION AND INTERSPECIALTY MEDICINE

Mr. Fox, in the absence of Dr. Ladyman, reported that the Commission on Continuing Education and Commission on Interspecialty Medicine had met jointly to discuss the past annual session and plan the 1974 Annual Session. The two groups discussed revision of the Bylaws by the House of Delegates during this year's annual session regarding introduction and processing of resolutions. The joint Commissions recommended that for one more year at least, the present time schedule should be retained and, pending experience at the Kansas City meeting in 1974, time schedule revision would be reconsidered. It also was recommended that the General Session on Saturday morning be replaced with one or more scientific sessions sponsored by the respective specialties and that concurrent scientific sessions be set at a maximum of five.

Dr. Young's proposal for guidelines to set up a statewide CME program also was discussed. The Commission on Interspecialty Medicine agreed to contact their respective specialty organizations regarding development of guidelines. The Commission will request that the medical specialty representatives respond by Jan. 1, 1974, indicating their willingness to draft respective guidelines.

Dr. Franklin moved that the Commission's recommendations on the format for the Annual Session be accepted. Motion was seconded and carried.

Mr. Fox stated that the date of April 17-20, 1975, Chase Hotel, was being held for the 117th Annual Session and that the Hotel needs confirmation of this date. He indicated that other hotels in St. Louis had been checked, but none met our space requirements.

Dr. Hetlage moved that the above recommendation for the 1975 Annual Session be accepted. Motion was seconded and carried.

Dr. Hansbrough moved that the entire Commission report be accepted. Motion was seconded and carried.

Dr. Chandler stated that requests from Dr. Howard of the AMA had been received asking for names of individuals for various federal commissions and committees.

Often these come on such short notice, and there is not enough time to contact these individuals or prepare CV's on them. Dr. Chandler stated that we should be given more warning, and that he would like for Mr. Mortenson to carry this message back to the AMA and report back at the next meeting on the mechanism of recommending people.—**Referred to Reference Committee on Medical Education and Public Welfare.**

MEMBERSHIP COMMITTEE

■ Dr. Martin stated that some action needed to be taken in regard to the budgetary items in the membership committee report that had been given previously. He stated that some of the items in the report were of an immediate nature and need to be funded.

Motion was made that money be spent and other money budgeted for the purposes outlined in Dr. Martin's report. Motion was seconded and carried.

Dr. Chandler stated that Dr. Finnegan was present and, perhaps, he would like to say a few words. Dr. Finnegan thanked the Council for the nice presentation at the Annual Meeting. He stated that he is indebted to Helen Penn, Allen Smith and Jean Duensing, who have been managing editors since Dr. Finnegan has been Editor, for their real service to the Journal.

Dr. Judd stated that he did not have a Treasurer's Report at this time, but would present a full report at the September meeting.

Dr. Judd reported that a service offered recently by the AMA had come to his attention and that he would like to mention it at this time. On request, the AMA sends a survey team to local and state societies to examine methods of operation and make suggestions on various matters that could be improved. He indicated that the St. Louis Medical Society had looked at this and had requested the AMA to send a team to St. Louis. Dr. Judd stated that he would like to recommend that MSMA ask the AMA to send a survey team to the State Association. He indicated that this was not criticism of the operation of the Association, but might be a means of improving the association to make it more attractive to new members. This service is to be provided by the AMA without cost to the Association.

Dr. Martin asked who composed the survey team. Mr. Mortenson stated that this service is provided by the Field Service Department and consisted of five or six individuals selected by Mr. Layton, head of the Field Service Department. The team varies from state to state and covers a period of three or four days. He reported that the survey team looks at what the society is doing, whether it is doing it right and how the society can improve things. The motion was made, seconded and carried that the MSMA ask the AMA to send a survey team to the State Association.

Dr. Cope stated that he would like to present a suggestion in regard to long range planning and financing. He indicated that he had sent this suggestion to Dr. Dave Kerr, Chairman of the Planning Committee, and that it eventually would come before the Council.

Dr. Cope stated that many times requests for unbudgeted money were made and many good, worthwhile suggestions and ideas have gone down for lack of money. He stated that the Missouri State Medical Foundation is now funded at the level of about one-half million dollars and that loans are being repaid, although not as fast as desired. Dr. Cope said that his suggestion was that the special assessment each year now going towards the funding of the Missouri State Medical Association be continued, but be diverted into an "educational" fund for the use of the Council, with no more than one-half being used during the year and the other half used for an investment fund. We would have approximately $20,000 a year to use on special projects that are unbudgeted. Dr. Cope stated that we are in a position in which we have to balance what MSMA is doing against the needs of the society. He indicated that he merely wanted the Councilors to think about this.

It was pointed out that Dr. Chandler had previously mentioned the possibility of having an informal meeting of the Council on Friday evening before the Council Meeting to consider the material to be covered during the Council Meeting. It was indicated that this would be a meeting of the members of the Council only and that staff and guests would not be invited.

The motion was made, seconded and carried that such an informal meeting of the Council be held on Friday evening of the December meeting to formalize Councilor reports and go over Committee reports submitted prior to the meeting and other pertinent matters.—**Referred to Reference Committee on Reports of Officers.**

■ Dr. Chandler stated that the AMA has proposed that state associations and county societies appoint special committees to deal with the "sick doctor" problems. He indicated that "sick doctor" legislation had been introduced in this session of the General Assembly, but that it did not go anywhere. Florida has passed legislation of this type and copies can be made available to those who want them. Dr. Chandler stated that these committees would be established for the purpose of assisting a physician with certain problems. He stated that this probably should be referred to the Public Affairs Commission for study and report back.

Dr. Cope stated that, perhaps, an opinion should be obtained about this matter. He indicated he would like to know from a legal standpoint how much authority this type of committee would have.

Mr. McIntyre said that the "sick doctor" legislation would be a legal situation whereby the Board of Healing Arts could take away a license under certain circumstances and that it was his understanding that the committee proposed by the AMA would try to help the sick physician before he would come before the Board of Healing Arts.

Dr. Chandler stated that Dr. Cope's point was well taken and it did not require any action other than giving it to the legal counsel to report back at the next meeting.

Dr. Chandler stated that he had mentioned earlier about the possibility of having a leadership conference. This conference is provided by the AMA at no cost. Dr. Chandler indicated that, possibly, this could be held in late summer or early fall and would be a meeting for which the Councilors would pick young men who are being groomed for medical leadership to meet in a quiet area and get a "crash course" in what the AMA has to offer. Mr. Mortenson reported that he had contacted Mr. Enright of AMA who arranges these conferences, and he suggested the dates of August 11-12. He stated that the conference would consist of 40 people maximum and would cover topics of parliamentary procedure, the decision making process and the communications process.

Dr. Hetlage stated that he felt this is a very good idea, but he did not see how we could get this conference together by August. Also, there is a conflicting meeting date the same weekend. Mr. Mortenson stated that Mr. Enright also had suggested a date in February, 1974.

Motion was made by Dr. Hetlage that the leadership conference be accepted using the February date. Motion was seconded and carried.

NEXT COUNCIL MEETING

At the invitation of Dr. Cope, the next Council Meeting will be held on September 29-30 at the Ramada Inn in Columbia.

The Council adjourned to an Executive Session.—**Referred to Reference Committee on Reports of Officers.**

Meeting of September 29-30, 1973

■ R. Allen Chandler, M.D., Kansas City, Chairman, called the meeting to order. Those present were Drs. Chandler; E. A. Stricker, St. James; James C. Cope, Columbia; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; Walter T. Gunn, St. Louis; John N. Martin, St. Joseph; Lysle M. Bach, Hannibal; Max S. Franklin, St. Louis; Louis P. Hetlage, Troy; Robert Bregant, Jefferson City; William D. Bradshaw, Clinton; Claude Cooper, Thayer; E. T. Hansbrough, Popular Bluff; Stanley S. Peterson, Springfield; J. Loren Washburn, Versailles; Hector W. Benoit, Jr., Kansas City; William D. Mayer, Columbia; R. K. Noback, Kansas City; M. Kenton King, St. Louis; Herbert R. Domke, Jefferson City; Richard P. Bowles, Liberty; Messrs. Lee E. Mortenson, Chicago, Ill.; Allen D. Smith, Kansas City; Hollister Smith, St. Louis; Ray McIntyre, Tom P. Fox, Royal O. Cooper and C. C. Swarens, Staff.

APPROVAL OF PREVIOUS COUNCIL MINUTES

Dr. Chandler called the meeting to order and requested approval of the minutes of the June 2-3, 1973 Council Meeting. On motion, duly seconded, the Council minutes of June 2-3, were approved as printed in the August, 1973 issue of Missouri Medicine.—**Referred to Reference Committee on Reports of Officers.**

EXECUTIVE SECRETARY'S REPORT

■ Mr. McIntyre indicated that the American Hospital Association is still trying to promote its Quality Assurance Program (QAP) and is holding regional meetings in order to acquaint people with its program and is trying to get backing. Such a meeting was held in Kansas City on August 15 and 16. Persons attending this meeting were from hospital associations, state medical associations, health departments, representatives of CME programs and others.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ A meeting, held in Jefferson City on August 27 at the Ramada Inn, was called by the Regional Office, Department of HEW, to give organizations and individuals an opportunity to appear before this hearing and make recommendations on areas for PSRO designations. It was pointed out that the Health Care Foundation of Missouri made a recommendation which was supported by MSMA.

Mr. McIntyre stated that at the PSRO hearing, there were local medical groups who proposed five area PSRO designations. The first recommendation of the HCF was that it be designated as the PSRO for the state of Missouri. However, if there are local PSROs set up as presented, the HCF asked to be designated as the administrative coordinating agency for the entire state.

He said that Dr. Benoit would speak again on the PSRO hearing later in the meeting. Approximately 50 physicians from all over the state were present at this meeting. It was reported that Dr. Bauer had resigned as the Director of the PSRO section of HEW and a Dr. Simmons is acting in that position.—**Referred to Reference Committee on Resolutions.**

■ The Executive Secretary informed the Council that several staff members had been elected to offices of state organizations. Miss Jean Duensing, Managing Editor of Missouri Medicine, was recently installed as President of Missouri Press Women. About 175 women journalists belong to this organization and Jean was elected for a two-year term. We feel it is an honor to Jean and to the MSMA to have her in this capacity. A motion was made, seconded and carried that Jean be commended for her election to the presidency of this organization.

Royal O. Cooper has taken over the presidency of a newly formed organization—the Missouri Society of Association Executives. There is a national association, and there are two local societies in Missouri with which Allen Smith and Hollister Smith are affiliated. However, this is a newly organized state association spearheaded by Mr. Cooper. A motion was made, seconded and carried that commendation be granted to Royal for his election as President of MSAE.

M.D. Day at Missouri University will be on October 12-13. The MU-Nebraska football game is scheduled for October 13. The University of Nebraska Medical School will cooperate with the MU Medical School in presenting the scientific program for Friday.

Mr. McIntyre noted that Dr. Slickman, Speaker of the House of Delegates for the 116th Annual Session, was in attendance at the Council Meeting and welcomed him.—**Referred to Reference Committee on Reports of Officers.**

■ Mr. McIntyre pointed out that for the information of the Council there was a resolution in the folders having to do with the Missouri Psychiatric Association and their interest in having a resolution passed in the MSMA House of Delegates next spring which would provide for delegates from various specialty organizations of the state to be voting members of the MSMA House.—**Referred to Reference Committee on Constitution and Bylaws.**

■ Dr. Domke was kind enough to arrange for the survey, "Physician Manpower for Missouri," to be published in the May issue of Missouri Medicine. The Division of Health financed this and it is the most up-to-date Missouri medical manpower survey available for today. We know that reports of this are being read as newspaper clippings from various parts of the state are citing statistics from the report.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Mr. Swarens attended a meeting of the State Medical Journal Advertising Bureau in Atlanta recently, along with Dr. Finnegan. Journal advertising was considered. This is becoming quite a problem. Journal advertising is more difficult to obtain and, at the same time, printing costs, postage, etc. are rising. Consequently, we are trying to keep informed on what different states are proposing.

A letter answering questions regarding Phase IV was sent out from the MSMA office along with one of the weekly issues of *AMA Newsletter* for posting on hospital staff bulletin boards.

Mr. Swarens indicated that October has been designated as Immunization Month in Missouri by Governor Bond. He pointed out that the current issue of *JAMA* has a good article on immunizations. The publicity will be aimed at parents, requesting them to call their physicians and bring their children up to date on their immunizations.

Mr. McIntyre reported that the Missouri State Board of Registration for the Healing Arts has denied Dr. Finch the right to take the examination for licensure. However, the administrative hearing commission ruled that the Board of Healing Arts is wrong and that Dr. Finch should be allowed to take the examination. Probably the Board will file suit to have the ruling declared invalid.—**Referred to Reference Committee on Reports of Officers.**

REPORTS OF DISTRICT COUNCILORS

■ *District #2*—Dr. Bach reported that he had recently attended a meeting regarding a commercial concern organization to run PSRO. He felt the tenor was that it had the approval of the Health Care Foundation of Missouri.

District #3—Dr. Franklin reported that he had attended the AMA Meeting in New York City. He indicated his Society's regret at the loss of Dr. Neilson and said that Dr. Robert Kelley had served as Dr. Neilson's replacement Delegate at the AMA Meeting.

The motion was made by Dr. Franklin that Dr. Robert Kelley be officially made an AMA Delegate to replace Dr. Neilson to Jan. 1, 1974. The motion was duly seconded and carried.

A motion was further made, seconded and carried that Dr. Hubert A. Ritter be appointed as Alternate Delegate to serve in that capacity to Jan. 1, 1974.

Dr. Franklin reported that the survey team from the AMA made its survey of the St. Louis Medical Society on September 16-19, and it seemed to go off very well. The annual pictorial roster of St. Louis Medical Society members has taken much staff time.

St. Louis Medical Society has voted to renovate its building rather than move. St. Louis Medical Society is raising its dues from $75 to $100 for the coming year. **—Referred to Reference Committee on Reports of Officers.**

■ Dr. Franklin indicated that, at the present time, his Society is not supporting the Open Panel Program of Blue Shield. Dr. Judd stated that the Society approved the concept, but is opposed to it on several grounds, the outstanding one being that if you are not a participating physician, Blue Shield will not pay either the patient member or the physician. It makes referral of patients very difficult.

District #4—Dr. Hetlage stated that in his personal conversations, he did not find overwhelming disapproval of the St. Louis Blue Shield Open Panel proposed program. He said that there was a good amount of physician input into this program and he could see reason for such further input.—**Referred to Reference Committee on Resolutions.**

■ In District #4, there is a crises of ambulance service. The undertakers will cease their ambulance service on January 1, and there will be no such service in Lincoln County. Dr. Hetlage indicated that he felt this is a serious medical problem and something needs to be done now.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ Dr. Hetlage voiced his concern that as PSRO foundations, organizations, etc. are set up, the structure of medicine may very rapidly change if these organizations take over the functions of the district and county medical societies. There is concern that these foundations, etc. may be making the medical decisions.

District #5—Dr. Bregant reported that his district is addressing itself to PSRO and have been meeting with the UNIMED people. This area would conform with Region B of the Health Care Foundation of Missouri.

District #6—Dr. Bradshaw indicated that there are no serious problems in his district at the present time.

District #9—Dr. Cooper reported that he had attended a meeting of the South Central Counties Medical Society. They discussed PSRO and decided that they want to go along with the HCF. They discussed continuing medical education and the work of MMPAC. Dr. Cooper stated that they are beginning to feel that they will have to get involved.

Dr. Cooper also attended a meeting of the Mid-Missouri Medical Society. Dr. Stanley Peterson was the speaker and made a fine presentation. Mid-Mo is reactivating its Society. They have changed their Bylaws so they might admit D.O.s into the Society.

Dr. Cooper indicated that he hopes something will come out of the meeting regarding some direction on Phase IV. Mr. Swarens reiterated some of the points that are included in the letter sent from the MSMA office on Phase IV.

Dr. Hetlage indicated that he would like to see the D.O.s in his area attend the society and district meetings so that all physicians will be working in the same direction. Considerable discussion was held regarding this matter. Dr. Hetlage stated that what he is really interested in is for MSMA staff to contact the Missouri Association of Osteopathic Physicians and Surgeons to see if these is some way that the practicing D.O.s can attend medical meetings and still be in good graces with their own organization. He said that they have been invited to many of his local and district meetings, but do not attend, supposedly because of their fear of being disassociated from their parent organization.

District #10—Dr. Hansbrough indicated that he would like to discuss the PSRO hearing in Jefferson City. About half of the presentation time was used by Dr. Burford, Cape Girardeau, explaining the Southeast Missouri Health Care Foundation, which essentially takes in the 10th Councilor District. He presented slides and explained the reasons for pointing out this district. The SEMO Health Care Foundation is the only local foundation in Missouri which is off the ground and has a program to present. About 15 months ago, the Cape Girardeau County Medical Society hired UNIMED, a corporation which had set up a functioning foundation in Denver. They were successful in signing up health insurance companies for the Denver foundation program. The basic purpose is to reduce health insurance premiums through the Foundation's physician peer review program. To finance the Foundation's program, health insurance companies or other third party payers cooperating, pay the Foundation a certain percent of their contract premiums. They, thus, expect, through the Foundation's peer review program, to reduce their patient care cost. The experience has been that they can save about 12% over what has been expended before patient care came under the foundation. Of that amount, about 6% goes into the foundation for operating expenses. The Cape Society hired UNIMED to do a survey in Cape Girardeau County where there are about 60 doctors. The conclusion was that this was not large enough. UNIMED came back with the proposal that the areas be expanded. Other physicians in Southeast Missouri then became involved by contributing money to have UNIMED do a feasibility study of the entire area, which is the 10th Councilor District, plus Jefferson County, which is a large county physician-wise, and also included Carter County which does not have a physician. This fills out the area and makes it possible to present maps showing that this is a functional area based upon trade routes, tradition, etc. There were 12 different ways in the presentation showing how this district was tied in as a unit. UNIMED concluded the study and said, indeed, this area is right for a rural health care foundation.

Dr. Hansbrough indicated that it was his understanding that as we go further along, cities may not get foundation approval in the future. The Bennett Amendment and probable HEW regulations seemed to make practical a PSRO area, since by including Jefferson County, there were 340 M.D.s and D.O.s in this area, which is Region E of the HCFM and identical to the 10th Councilor District. Immediately, the physicians in Southeast Missouri took up the idea.

Dr. Hansbrough stated that he felt that Dr. Burford's presentation at the PSRO hearing was thorough, complete and exceptionally well presented. At the encouragement of the Southeast Missouri group, other parts of the state are considering such feasibility studies by UNIMED.

The Executive Council of the Southeast Missouri foundation and the people doing the work, consist of each hospital sending a physician to be a representative on the Executive Committee of the corporation. Some of the smaller hospitals voiced concern that the larger hospitals and staffs would be telling the smaller ones what to do. However, they were assured that this would not be the case and they would have equal rights.

Dr. Hansbrough stated that there is a danger to this because these people have put so much time and work into this that, indeed, if there is a change in PSRO districts to allow state organizations as HCFM to do the whole job, perhaps the Southeast Missouri foundation will say, we would like to do ours, let them do the rest of the state. He stated that he is definitely enthusiastic about the Southeast foundation, but does not want to split the state. The physicians have indicated that they want to review only in their area and have the HCFM be the coordinator, since the word they now have from Washington is that a PSRO district will not be set up with more than 3,000 physicians.

Lengthy discussion followed regarding the pros and cons of such a foundation as explained by Dr. Hansbrough.

Mr. Mortenson indicated that as far as he knew, HEW has not officially discouraged the setting up of these foundations in a city area.

Dr. Hansbrough indicated that the cost of this to an individual family or the employer is an administrative thing and is being determined by UNIMED. They have indicated that they will need to operate this for two to three years at which time the help would be trained to carry on.

Concern was expressed over the fact that after these foundations have been set up, a time will come when the federal government will try to impose certain fee schedules, changes, etc. and we will be locked into a situation from which there is no escape, so there should be caution.

Further discussion followed regarding the Southeast Missouri Foundation. Dr. Hansbrough stated that he was a little disappointed in the fact that the *Journal* made practically no mention of the 45-minute presentation given at the PSRO hearing by the SEMO group.

Dr. Hansbrough reported that several months ago, several area physicians became interested in Comprehensive Health Planning and organized a Poplar Bluff Health Care Council. The first project was an approved ambulance training program in the junior college, which one of the physicians is teaching. Recently, a meeting was held to organize the Ozarks foothills into a B Agency under CHP. It is anticipated that the Poplar Bluff Health Care Council will organize a B Agency. Dr. Hansbrough indicated to the Council of MSMA that if you don't have a CHP agency in your area, get an organization set up to help the people in the area, but have definite medical input. This is so very important.—**Referred to Reference Committee on Resolutions.**

■ Dr. Hansbrough said that all of the undertakers in his area are going out of the ambulance business on January 1. Both Poplar Bluff and Cape Girardeau have private ambulance services. Some of the other counties are trying to have a working arrangement with these to go as far as 65 miles for ambulance service.

District #1—Dr. Martin indicated that the morticians are going to discontinue ambulance service in his area. However, they do have three ambulances, all run out of one of the hospitals. The problem has been the requirements to drive an ambulance. He further indicated that the morticians really tried to help the local people by getting out and pushing for a mill tax to support an ambulance service.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ Dr. Martin reported that a local group has taken over Sisters' Hospital in St. Joseph. They have an administrator and a local Board and it seems to be going along well.

Dr. Martin indicated that St. Joseph is in dire need of an anesthesiologist and asked the Council to please indicate to him if they are aware of anyone looking for a location.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Dr. Martin stated that he does not feel we have the relationship at the state level with the AMA that we should have. We do not have enough input to the AMA on a daily or weekly basis and we do not get enough back from the AMA. We need closer relationship. I think Missouri and maybe every state should have a staff person who can go into the AMA office and secure needed information and come back to us with it. Not that Lee Mortenson doesn't give us good service. He covers three states. We need someone to go up there from time to time from our state organization to find out what is going on.

Dr. Martin indicated that he was very disappointed when attending the AMA meeting in the fact that when they voted for the Board of Directors, it was interesting that there was only one man running for every office and that was the one sitting at the head table.—**Referred to Reference Committee on Reports of Officers.**

■ Dr. Martin indicated that he has been asked by several people to see a financial report of the Health Care Foundation of Missouri and he has asked for one, but has yet to receive one. He said that he would like to see one.

District #8—In the absence of Dr. McAlhany, Dr. Peterson gave a brief report for District #8. A Councilor District meeting was held on September 20 in Springfield. Mr. Dave Weihaupt of the AMA office in Chicago was on the program, along with Dr. E. A. Stricker, President of MSMA. Mr. Weihaupt stated that PSRO is here and we should remember one basic thing—that it is a regulatory arm of the U. S. Government.

Dr. Peterson reported that one of the not-for-profit hospitals in Springfield was taken over by a for-profit organization and Blue Cross indicated that they could not pay for-profit organizations. Later, they indicated that they would not pay because Springfield had too many hospital beds anyway based upon the state plan which indicates that Springfield is overbuilt. However, Blue Cross is now paying this hospital. Dr. Peterson indicated that this was an example that if the community is right, nobody from some place else should be making your decisions.—**Referred to Reference Committee on Resolutions.**

■ *District #7*—Dr. Chandler reported that the Jackson County Medical Society Medical-Legal Committee has worked diligently and has come up with a final draft of its proposed interprofessional code. Dr. Chandler indicated that he thought it was excellent and will pass it along to the Chairman of the MSMA Commission for any help it might be to them.—**Referred to Reference Committee on Constitution and Bylaws.**

■ Jackson County Medical Society has instituted a membership campaign aimed at the 335-plus-or-minus physicians in the county who presently are not members.

The Medical Business Bureau in Jackson County is contemplating the establishment of a placement service for employees in physicians' offices. They presented their proposal to the Jackson County Council and were given an okay to go ahead with the study for the establishment of such a service.

PRESIDENT'S REMARKS

Dr. Stricker reported that he had attended many meetings during the past summer. At the AMA Convention in New York, he attended the State Presidents' meeting. This was attended by many state presidents and foreign dignitaries. The meeting was well worthwhile.

He said that he had attended the Blue Shield workshop meeting held at the Lake of the Ozarks this past summer.

Dr. Stricker also attended the Mid-Mo Medical Society meeting at which Dr. Stanley Peterson gave an interesting presentation on the Missouri Physicians' Guild.

Dr. Stricker stated that he had attended the Kentucky Medical Association convention recently and truly enjoyed the Southern hospitality. Presidents of six other states were in attendance at the meeting. He indicated that he attended the Councilor District meeting in Springfield at which Mr. Weihaupt spoke.—**Referred to Reference Committee on Reports of Officers.**

MSMA SPONSORSHIP OF FUTURE TOURS

■ Mr. Cooper reported that the Rhine Escape tour would leave on Sunday, October 7. This tour was oversold with about 75 on the waiting list. Several other trips are being planned—one European trip by Intrav in June, 1974 and a Grecian tour by Marriott in August, 1974. Mr. Cooper asked if the Council might be interested in a post-convention trip, such as to Las Vegas for four days for about 100 persons, $200-$225 including stay at Caesar's Palace. Discussion followed as to whether such a trip might enhance the attendance at the Annual Session or hinder such attendance. On motion, duly seconded, it was agreed that MSMA not sponsor such a post-convention trip.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORT OF BUDGET AND FINANCE COMMITTEE

■ Dr. Judd, Chairman of the Finance and Budget Committee, gave the following report:

The Budget and Finance Committee of the MSMA met at the MSMA Offices in Jefferson City on September 9, 1973. Present were Donald Judd, M.D.; James C. Cope, M.D.; E. A. Stricker, M.D.; Howard McAlhany, M.D.; and Mr. Ray McIntyre.

Allen Chandler, M.D., was ill and unable to attend. Mr. Gerald Sandweg and Mr. Oliver Wilkins of the Mercantile Bank of St. Louis met with the Committee. The following items were considered:

1. *MSMA Building*—MSMA has borrowed $120,000 from the Mercantile Bank at 7% annual interest. This loan expires in early October, 1973. The Mercantile Bank desires to terminate the present loan and will establish a conventional real estate first mortgage loan for 15 years at 7% on the MSMA building and furnishings. The Bank is willing to loan up to 80% of a conservative appraisal of the value of the MSMA building and building site. Such an appraisal has been completed with the appraised value of $100,000. Thus, Mercantile will extend the loan up to $80,000 at 7% annual interest, to be paid within 15 years. The payments are to be made in level monthly payments. Prepayment of any portion of the loan can be made without penalty.
2. *Loan Payment*—To reduce the present loan from $120,000 to below $80,000, a motion was made and unanimously passed that MSMA sell bonds from its investment portfolio and apply the proceeds to the reduction of the present loan. The recent market value of these bonds was $48,331.00. Applied to the present loan, this would leave a mortgage loan of approximately $72,000 with annual payments of approximately $7,765 per year. The recent stock market situation would make sale of any stock unwise at the present time.
3. *Budget*—A more detailed budget will be submitted in December. Advertising revenue from the MSMA *Journal* is less than anticipated.
4. *Recommendation*—MSMA dues are low in comparison to those in other states. Our present dues are $65 per year with a $10 per year special assessment for the Missouri State Medical Foundation. The Foundation has about $487,000 loaned out at present. The assessment produces about $38,000 per year. It is recommended that this assessment for the MSMF be discontinued and that the MSMF continue to be supported by interest on loans, gifts and bequests. The assessment would be directed to the following:
   a. Reserve fund—50%
   b. Special projects—50%—Retirement of building fund, continuing education, etc, that the Council deems wise.

   This requires approval by the Council and House of Delegates.
5. *Assignments*—The Council must decide officially who can execute assignments on behalf of MSMA.

(Left to right) Dr. Andrew McCanse, Kansas City, newly-elected Councilor for the Seventh District, with Third District Councilor Max S. Franklin of St. Louis, who was elected Chairman of the MSMA Council, and Eighth District Councilor Howard J. McAlhany of Springfield, who was elected Vice-Chairman.

Dr. Judd stated that approval by the Council and House of Delegates would be necessary regarding Recommendation #4 of the Committee's Report, and the Budget and Finance Committee proposes such a resolution to implement this recommendation.

Dr. Matthews stated that there is need for more operating revenue and that, perhaps, rather than ask for a revolving assessment, a dues increase should be considered. Dr. Mayer pointed out that the need for student loans is increasing and that he felt the MSMF assessment should be continued.

Dr. Judd stated that the pros and cons of this matter had been discussed at the Committee meeting and it seemed obvious that a time will come when the Association will need to balance what they have done for the medical students against what needed to be done for physicians who are members. The time should come when the money coming back in repayments can be turned around and be loaned to students and still provide adequate funding for the student loans. Several other officers and councilors expressed their views on discontinuance of the assessment and proposed dues increase.

Dr. Martin moved to table the resolution. Motion was seconded and carried.

A motion was made to approve selling the bonds indicated above, which authorization was given the Finance Committee by previous action of the Council and the 1973 House of Delegates. The motion was seconded and adopted.

Dr. Judd stated that the Council needs to decide officially who could execute assignments on behalf of MSMA. A motion was made that the President of the Association be authorized to execute assignments on behalf of MSMA. Motion was seconded and adopted.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF LEGISLATIVE COMMITTEE

■ Dr. Matthews reported that the Committee had met on Saturday morning and had discussed proposed legislation to be introduced in the upcoming session of the General Assembly. He indicated that this will be a short legislative session and most proposed legislation would have to be pre-filed if it was to get anywhere.

Dr. Matthews stated that the Legislative Committee, in cooperation with the ophthalmologists, had developed a delegation amendment. He stated that Council approval was needed.

A motion was made by Dr. Cope to approve this portion of the report. Motion was seconded and carried.

Dr. Domke stated that an Attorney General's opinion had been obtained on midwifery and that the opinion and the proposed legislation might be in conflict. He stated that, perhaps, this should be referred to the Board of Health to get an Attorney General's opinion. Dr. Matthews indicated that this could be done, but that the bill would have to be pre-filed if it is to get anywhere in the Legislature.

A motion was made that this proposed legislation be referred to the Board of Health and an Attorney General's opinion be obtained. The motion was seconded and adopted.

The next item discussed by the Legislative Committee was "sick doctor" legislation. Dr. Matthews stated that this legislation was introduced late in the last session of the General Assembly and received a favorable response from legislators. The intent of this legislation is to help the "sick doctor" obtain treatment. He indicated that special articles on this subject would be printed.

A motion was made to adopt this portion of the report. The motion was seconded and adopted.

A laboratory licensing law was discussed by the Legislative Committee. A similar bill had been introduced previously. Dr. Matthews indicated that the intent of the bill was to properly regulate laboratories doing commercial work.

A motion was made by Dr. Gunn for approval of this section of the report. Motion was seconded and carried.

Dr. Matthews next discussed Resolution #9 from the 1973 MSMA House of Delegates, which called for comprehensive coverage for newborns in insurance policies. It was felt by the Committee that going through the Legislature is not wise and that this matter should be directed to the Insurance Department and the Health Insurance Council.

Legislation regarding physical therapists was considered by the Legislative Committee. This legislation would allow only licensed physical therapists to represent themselves as physical therapists.

A motion was made to adopt this portion of the report. The motion was seconded and carried.

Dr. Matthews reported that there are rumors that a bill may be introduced which would specify the number of hours of continuing education for annual registration.

Dr. Matthews stated that our legislative record for the past session was good and that this was due to a lot of hard work on the part of Royal Cooper, Cork Swarens and Ray McIntyre, who deserve a lot of thanks for their efforts.

Mr. McIntyre stated that he, Royal and Cork were grateful for Dr. Matthews comments and his confidence, but he would be amiss if he did not mention that Dr. Matthews had testified at hearings and that without his help and advice, the staff would have been much less effective.—**Referred to Reference Committee on Miscellaneous Affairs.**

REPORT OF LEGAL COUNSEL

■ Mr. McIntyre stated that Mr. Noble, who was ill and unable to attend the meeting, had sent a letter regarding the progress in the lawsuit relating to the HCF now under appeal. The letter indicated that (1) Respondents' motion for extension of time to Oct. 15, 1973 to file brief has been granted by the Court; (2) Brief will be filed on or before October 15 and a copy will be sent to Ray McIntyre; (3) Since the appellants failed to perfect their appeal on Count II of their suit, which was the Count directed against the Health Care Foundation of Missouri, the judgment of the Trial Court in favor of the Health Care Foundation of Missouri is final.—**Referred to Reference Committee on Resolutions.**

REPORT OF MMPAC

■ Dr. Martin reported that resolutions regarding PAC had been passed at the April Council meeting, but that they had not been implemented.

Mr. McIntyre stated that there had been questions concerning what activities the personnel of MSMA could take regarding PAC. He indicated that there had been contact with Lee Mortenson and the Legal Counsel of AMPAC and the AMA regarding this question and whether *Journal* pages can be used for PAC. Mr. McIntyre stated that our CPA was also concerned as to exactly what the staff could do in regard to PAC.

Dr. Martin stated that other states have gotten into this and that it was his understanding that activities which didn't deal directly with specific candidate support can be classified as educational activities.

Mr. Mortenson outlined how some other states handle staff time spent on PAC and how this was paid for. Each state mentioned handled things in different ways. Dr. Hetlage stated that physicians need to be educated to think along political lines without mentioning candidates. Dr. Martin reported that PAC Bylaws had been rewritten and that the size of the Board is going to be increased. The Board will consist of two members from each of the Councilor Districts (at least one of whom is to be a physician), President of MSMA, President-Elect of MSMA, Chairman of the Council, a Woman's Auxiliary Representative and the Executive Secretary of MSMA.

Dr. Martin stated that some resolutions regarding membership also had been passed. Mr. Swarens stated that letters are going out to new members, to members who are renewing only MSMA and to members who are renewing both MSMA and AMA membership. He indicated that an MSMA brochure and an AMA brochure were supposed to be sent out, but the AMA brochure has not been received and the MSMA brochure is almost ready to be printed. He stated that no direction was given as to when these brochures are to be sent out, but it seemed practical they be sent out with the next dues billing.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF AMA DELEGATES

■ Dr. Washburn gave the following report of the AMA annual meeting held in June:

"This Council has already sadly acknowledged the death of Art Neilson. Your AMA Delegation would like to add its sincere feeling of loss on the passing of Art and its heartfelt condolences to his wife, Janet, and the family. Art was a truly dedicated and competent man in many fields and activities, and we shall all miss him. Staff has been directed to submit a memorial resolution to the AMA for presentation at the Clinical Session.

"I will attempt to present a brief summary of the AMA House of Delegates action in New York. It was the largest business session in the history of the AMA. Meeting for a total of almost 19 hours, the House acted on 84 reports and 179 resolutions for a total of 263 items of business.

"As most of you know, Hector Benoit was successful in his reelection bid for the Council on Medical Service. Bob Kelley, who filled in for Art, did an obviously effective job in directing Hector's campaign. Dr. Russell B. Roth of Pennsylvania, who spoke at the MSMA Convention two years ago, was installed as President of AMA and Malcom C. Todd of California, was selected as President-Elect.—**Referred to Reference Committee on Reports of Officers.**

■ "The resolution presented by the Missouri Delegation which expressed concern over disruptive socioeconomic influences in medical practice and urged a "hard line" in dealing with those influences was not adopted. However, a substitute was adopted which stated: "That Officers and the Board of Trustees of the AMA take steps to increase the capacity of the AMA to speak with authority in representing the interest of the medical profession and the public in the socioeconomic areas."

"Issues discussed ranged from PSROs and wage-price controls to institutional licensure and the need for more primary care physicians, as follows:

PSRO's—Resolutions were passed informing HEW that peer review for physicians can be carried out only by organizations composed of practicing physicians and that since many such organizations are now in existence, HEW rules and regulations should be written to allow existing peer review groups to function as PSROs. The House also recognized that repeal or modification of PSRO legislation may ultimately be required to preserve high quality of patient care.

Wage-Price Controls—The AMA is to work for an end to discriminatory treatment toward physicians under the controls.

FDA Regulations—The AMA will continue to protest current and proposed FDA regulations which restrict the use of prescription drugs to "official labeling" and make an effort for establishing better communications between the practicing physician and the FDA.—**Referred to Reference Committee on Resolutions.**

■ *QAP*—The House expressed reservations about the American Hospital Association's proposed peer review mechanism and the AMA representatives will meet with the AHA to offer suggestions.

Support for Medical Staffs—It was resolved that any arrangement between hospital board of trustees and its medical staff that conflicts with the AMA principles of ethics and that unilateral changes in medical staff bylaws by hospital trustees are improper.

Physicians on Hospital Boards—The House called for increased medical staff representation on hospital boards, asked state and local medical societies to remove barriers to such representation and requested the JCAH to ascertain the effectiveness of communications between hospital governing boards and medical staffs.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ *Certificate of Need*—The new Social Security Law, which more-or-less places certificate of need regulations in effect regardless of state laws, was discussed and the AMA will continue to support voluntary planning that preserves decision-making on the local level and seek the participation of practicing physicians on planning boards.—**Referred to Reference Committee on Resolutions.**

■ *Primary Care Physicians*—The AMA is to publicize and promote a goal to have at least 50% of all medical graduates enter residency training in the primary care specialties in the coming years. Also, the AMA is to continuously monitor the need for number and types of physicians.

Medical Schools—The House adopted a report which presented the essential characteristics by which a medical school is accredited, thus bringing up to date a document last revised in 1957.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ *Unions*—Unionism among self-employed physicians was opposed, but AMA will maintain its interest and concern in those physicians in employment situations who need assistance and support.—**Referred to Reference Committee on Resolutions.**

■ *Malpractice*—The formation of a Medical Liability Commission to represent health care providers in dealing with medical malpractice problems was approved. The Commission will consist of representatives of the AMA, AHA, American College of Surgeons, American College of Physicians and four specialty societies.—**Referred to Reference Committee on Constitution and Bylaws.**

■ *Internal Matters*—The House added a resident-intern member to the Council on Medical Service and Council on Medical Education, but defeated a move which would have separated the scientific meetings from meetings of the House. Also, the House changed the dues setup so that the delinquency date for AMA dues is April 30, rather than June 1, each year and eliminated the requirement that members dropped for nonpayment must pay one year's past dues.

"Regarding the AMA Board of Directors, the House instructed the Council on Constitution and Bylaws to prepare for the 1973 Clinical Session a measure that will allow the House to vote on whether Trustees shall serve a maximum of two three-year terms. Now, Trustees may now serve up to three three-year terms.

"*In Other Action* the House reaffirmed the AMA abortion policy which states that 'abortion is a medical procedure and should be performed only by a duly licensed physician in accredited hospitals acting only after consultation with two other physicians, and in conformance with standards of good medical practice. . . .'

"Also, the House voted to support and collaborate with efforts to set up #911 as the nationwide emergency telephone number.

"And, the House encouraged state medical societies to support medical licensure law amendments to permit out-of-state physicians to practice temporarily in areas of medical need.

"And, finally, Bob Hope, who was presented the AMA Citation of a Layman Award for his philanthropy on behalf of medical facilities and causes across the country, was one of the highlights of the Convention as he entertained delegates with the unique comedy only he can offer."

Dr. Washburn stated that the AMA delegates had been spread rather thin because of the campaign for Dr. Benoit and the help of the staff and officers throughout the meeting was most important. He said that sometime in the past, the Council had made a policy that the senior AMA delegate should report on AMA meetings to the Council. Dr. Washburn reported that he thought this should be changed due to the fact that each delegate covers different areas during the AMA meeting and that it would be better to have each report on what he covered. He indicated that the possibility of only opening the MSMA Hospitality Suite for one night at the AMA clinical meeting was being considered.

Dr. Washburn stated that if it is feasible during the MSMA Annual Session, an informal meeting could be set up so that members of the Association could meet with the AMA Delegates and Alternates to ask questions, give criticism, etc.

A motion was made that the suggestion that the AMA Delegates and Alternates meet with members of the Association at the Annual Session be implemented. Motion was seconded and carried.

A motion was made to approve the AMA report as received. Motion was seconded and carried.—**Referred to Reference Committee on Miscellaneous Affairs.**

REPORT OF BUILDING COMMITTEE

■ Dr. Matthews stated that the MSMA's new building is now completed and he hopes that the Councilors will urge members in their districts to visit the new headquarters.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF MEDICAL SCHOOL DEANS

■ Dr. King reported Washington University Medical School has 120 freshman students and that by next year, the total student body would be 480.

Dr. Noback reported that there were 72 new students in Year 1 and 40 at the Year 3 level in Kansas City. He stated that several new faculty members had been added. There were 40, Year 2, students in preceptorships in Kansas City and Western Missouri this past summer and it is hoped that this can be expanded to include areas outside of Western Missouri.

Dr. Noback mentioned that several students had taken Part 1 of the National Boards as noncandidates. He indicated that the Western Missouri Health Education Center now has the cooperation of the dental and pharmacy schools. He reported that the groundbreaking ceremony had been held for the new Truman Medical Center, which will replace the present General Hospital.

Dr. Mayer reported that Joseph White, M.D., had been appointed as the Provost for Health Affairs at the University of Missouri. He indicated that Dr. White had hoped to attend the Council meeting, but had a prior commitment. Dr. Mayer stated that Dr. White would like an opportunity to get to know the Council members.

Dr. Mayer indicated that there had been considerable discussion recently about the Missouri Institute of Psychiatry. Correspondence regarding experimentation on humans was sent to Dr. Harold Robb, Governor Bond and Congressman James Symington. Congressman Symington has asked the FDA to look into matters relating to human experimentation.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Dr. Mayer indicated that he, personally, would be supportive of an increase of dues and that he did not want to see the loss or decrease of loan funds for medical students. We would be decreasing loans at a time when there is increasing needs.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF DIRECTOR OF DIVISION OF HEALTH

■ Dr. Domke stated that the Board of Health had been asked to prepare a brochure on recommended immunization procedures.

Dr. Domke stated that he would like to talk about the ambulance situation. The ambulance regulation law does not become effective until July 1, 1974. The funeral directors in Missouri are going out of the ambulance business. At this time, half of the state is now covered by substitute ambulance services. There is a statewide concern regarding this matter. In rural areas particularly, perhaps there could be a hospital-based ambulance service. In metropolitan areas, there are private ambulance services. Dr. Domke reported that since the ambulance district law has gone into effect, some 20 districts have been voted in around the state. It is the basic policy to make ambulance service a local responsibility. Dr. Domke stated that there is a great deal of interest and concern about this problem, but that it would have to be resolved locally. He reported that the ambulance bill calls for ambulance, training and equipment to meet American College of Surgeons standards.—**Referred to Reference Committee on Miscellaneous Affairs.**

AMA REPORT

■ Mr. Mortenson reported on several items. On national legislation, he indicated that the Keogh Plan change should be satisfactory to everyone involved. The PSRO National Council has indicated that there will be a state and local option plan. Mr. Mortenson stated that he had talked with the sponsor of the House HMO bill and that it looks like there will be an HMO bill coming out of the House. He said that, hopefully, this bill can be amended satisfactorily. The bill will be an experimental, limited HMO bill.—**Referred to Reference Committee on Resolutions.**

■ The dates selected for the Leadership Training Seminar sponsored by the MSMA are February 23-24, 1974.

Mr. Mortenson stated that the AMA had not as yet received the MSMA request for a survey. He reported that the St. Louis City and St. Louis County Medical Societies' surveys have been made.

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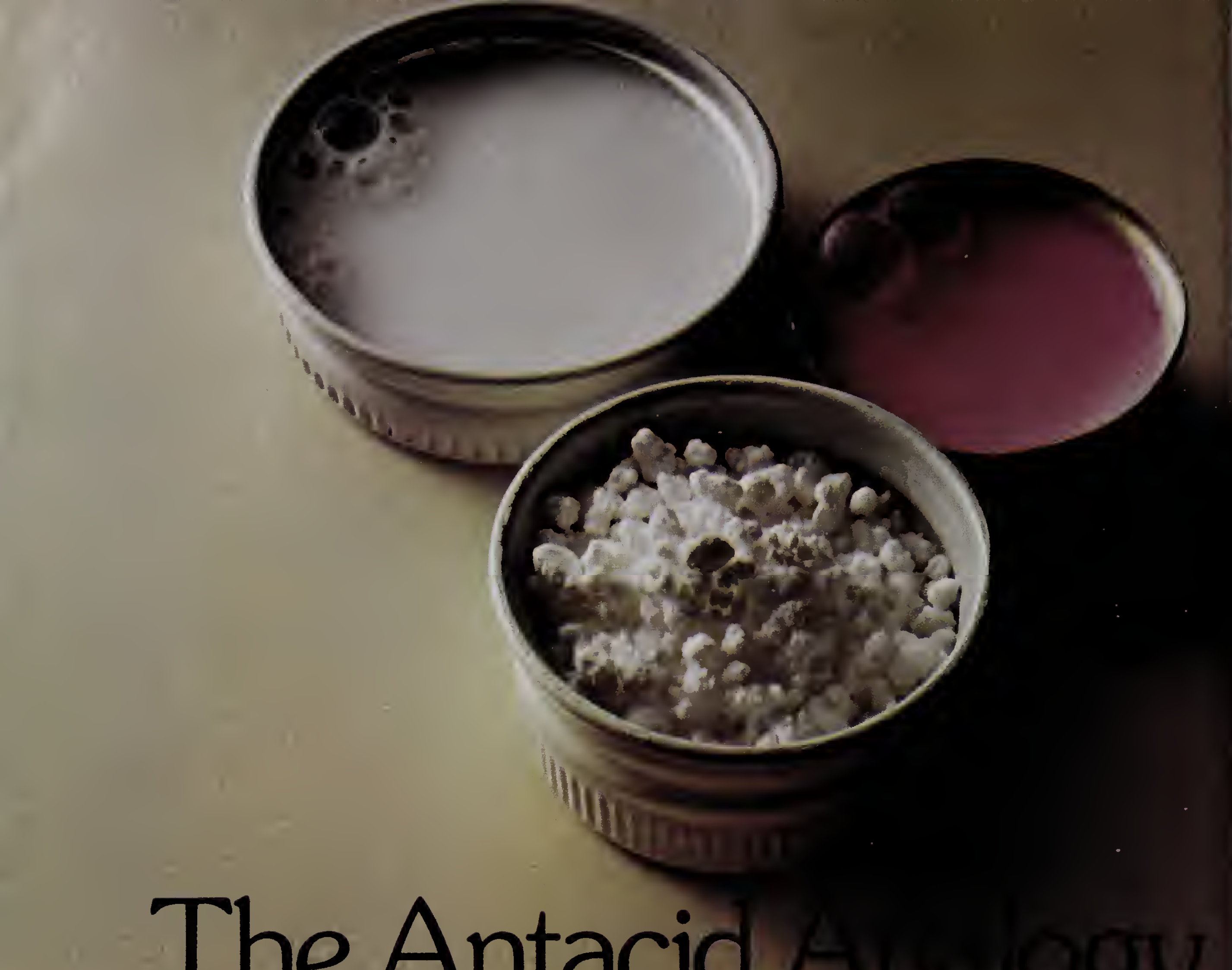

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

SK&F CO.
Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

*Serum Potassium Level Drops During Long-Term Exercise, *Medical Tribune*, July 4, 1973.

†No implication that 'Dyazide' is useful in preventing K⁺ loss in athletes is intended.

Mr. Mortenson reported that he is sending a memo to all state and county societies in his area setting forth the new decisions the AMA House of Delegates made on membership.

COMMITTEE OF ARRANGEMENTS

Dr. Chandler appointed the following committee on arrangements for the 116th Annual Session: Dr. Chandler, Chairman; Drs. Bradshaw and Martin.

The Council Chairman commended Dr. Cope for the lovely party held the evening before and on his lovely family.—**Referred to Reference Committee on Reports of Officers.**

HCF AND PSRO

■ Dr. Benoit indicated that the HCF has problems and is in a state of flux. He gave a brief rundown regarding the SEMO foundation and its relationship with UNIMED. The HCF Board has met with UNIMED representatives who assist in setting up and initially operating health care foundations similar to the Denver Foundation for Medical Care. It was the Board's feeling that the UNIMED approach is good. The Board has elected to permit the Executive Committee to work out some arrangement with UNIMED. In dealing with all the various problems implied in PSRO, he said you must develop a flexible plan so you can move in any direction that may become feasible. The AMA has strongly urged HEW to allow state option on statewide PSRO designations. The National Advisory Council of PSRO has taken a positive position in their recommendation to Secretary Weinberger that statewide PSROs be allowed in those states where it appears feasible.

As UNIMED viewed it, the best thing to do was take HCF's original structure and with the five review areas, develop them more autonomously in line with the recent changes in the Bylaws, to structure it so that each area could, if necessary, be identified as a separate PSRO and the current HCF could become the coordinator. The Board felt this was an appropriate approach and if, indeed, the Secretary of HEW was willing to sign a single contract within the State, the HCF would be eligible for such a contracting arrangement, with the subcontracts to each of the five individual areas and HCF as the coordinator.

Dr. Benoit expressed his feeling that a position of unanimity of thought and ability to be heard when contract time rolls around would be better if we have a single contracting agency within the State such as the HCF. He feels it would be better if HEW dealt only with one office rather than dealing with different areas of the state at different times and possibly setting double and triple standards.

Dr. Benoit then reported on the hearing on PSRO held in Jefferson City on August 27. Each of the major physician organizations in the state—MSMA, MAOPS and the HCF—and a spokesman from areas approximating each of the five HCF peer review regions of the state presented proposals with some degree of unanimity. Dr. Benoit said he would not discuss further the SEMO Foundation proposal since he understood that Dr. Hansbrough had covered that. The HCF proposal included the option to have the secretary sign a unilateral contract with just the HCF for PSRO activities within the state, but also indicated its willingness to be the coordinating agency if the secretary chose to make contractural arrangements with different portions of the state. HCF shifted a few counties into different peer review areas. This was done to accommodate physicians in a given county who expressed where they wanted to be located. Physicians in both Wyandotte and Johnson Counties in Kansas, who do much of their hospital work in Kansas City, Missouri, have indicated to their spokesmen they want to be a part of Kansas's PSRO activities rather than Missouri's.

Dr. Benoit stated that as this thing with PSRO evolves, it is possible there might not be a HCFM. This would be detrimental to the physicians and the patients in the state if it happens. What we want to do in peer review is still needed as it was back in 1969 when the HCF was born, is totally defensible and would be to the benefit of all concerned. If we are forced to carry it out under a governmentally structured situation, now identified as PSRO which is going to completely identify itself with cost curtailment and in no way consider the benefits of the patient or the physician's ability to take care of that patient, then we are in very serious trouble and it is the one trap we have to be careful not to fall into.

Dr. Benoit then indicated some of the things going on at the AMA level. The AMA Advisory Committee on PSRO established and organized in January. Four full committee meetings have been held. Dr. Benoit chairs the task force concerned with geographical distribution. The most active task forces have to do with data collection and proper handling. They are extremely concerned with the possibility that all confidentiality of the patient-physician relationships could be lost. If this data handling can be done by coding so that some degree of anonymity is preserved, this is one thing we are striving for. The Task Force on Regulations has developed an initial draft of regulations which are broad and leave room for local modification.

The Task Force Committee on Guidelines and Norms attempted to develop broad guidelines and norms of diagnosis and treatment which will be only a guideline to local PSROs.

It was indicated that Dr. Bauer had resigned, and Dr. Benoit discussed some of the possibilities for his replacement. Senator Bennett is considering introducing an emergency amendment in Congress proposing that the PSRO legislation be entirely administered by SSA.

HR 1 now includes the extension of Medicare beneficiaries to everybody under treatment of chronic instage renal disease. The National Kidney Foundation was called on to draw up proposed regulations for its implementation. Many nephrologists voiced their dissatisfaction to virtually all of their proposals. Dr. Benoit became involved in a special committee of AMA to handle this problem. This Committee feels there is no need to set up a separate review system and that pay for a chronic renal problem should not be any different than for a diabetic, cardiac, etc. One of the proposed regulations has to do with the structure under which certification of centers would be achieved. You would have to have done 25 transplants in the past year to be eligible. Three agencies—AMA, ASIM and a group known as physicians for renal replacement—presented a position paper to HEW through Dr. Edward's office proposing certain basic concepts as follows: (1) No reason for reimbursement other than by traditional methods; (2) Review should be done starting with as local an area as possible; (3) Certain criteria should be developed by people in nephrology which would indicate as least the minimum for an acceptable facility to carry out renal dialysis. Another item which AMA felt strong about is that there should be inducement to patients to go on home dialysis.

The Council on Medical Service has considered a number of AMA resolutions regarding confidentiality. There are certain areas in which it has become common practice for insurance companies to come in and photograph patient records. They have a blanket consent.

The insurance commissioner in Pennsylvania about 1½ years ago came out with 39 proposed guidelines which he proposed should be incorporated into any contract drawn up between Blue Cross plan and any hospital in Pennsylvania. This list now numbers 67 and they are something. This was brought to the AMA's attention, which in turn gave it to three committees of the Council for study and recommendation. Dr. Benoit indicated that he would say 50 of these items are in violation of what most physicians consider good medical principles.

Dr. Benoit then spoke on a program presently under day in Wisconsin on a pilot basis—the Wisconsin Health Maintenance Program. A very knowledgeable man from the NABSP office went over this with the AMA Council on Medical Service. He thinks it combines the best of what physicians want in PSRO and what certain governmental people want in HMO.

Discussion followed regarding Dr. Benoit's presentation. The question was raised as to whether by one piece of legislation, namely HR 1, have we gotten ourselves in a position of being forced to change the structure of organized medicine. Dr. Hetlage expressed concern that these various foundations being set up in the state would encompass the whole practice of medicine and the local, state and ultimately the national medical societies will be bypassed. If one company would set up several foundations in the state, this company could render itself extremely powerful.

Dr. Benoit stated that he did not feel this was a threat. Dr. Hansbrough stated that representatives of UNIMED went to every hospital in his district and from the beginning organized medicine was informed. UNIMED is interested in organization and not operation.

Dr. Benoit pointed out that physicians at the level of the Board of Trustees of AMA and the Council on Medical Services are beginning to feel that the UCR concept is in serious jeopardy.

Dr. Peterson indicated that everyone must remember that a health care delivery system and a PSRO are not the same thing. One is a health care delivery system and the other is a regulatory arm of the federal government.

The Chairman thanked Dr. Benoit for an excellent report.—**Referred to Reference Committee on Resolutions.**

REPORT ON CHP

■ Dr. Robert Kelley stated that he felt it is about time that the Council be informed about what is going on in CHP in Missouri. He stated that, basically, one of the questions that requires resolving at this point in time is what attitude does the Council of MSMA and the individual members take toward CHP. Dr. Kelley stated that several attitudes had been expressed personally to him by physicians from around the state.

Dr. Kelley stated that he had gotten into CHP by reason of MSMA's suggestion to Governor Hearnes that he should be on the Governor's Advisory Council for CHP. He reported that during the two years he has been Chairman of the Governor's Advisory Council, the Council has been reorganized and there has been considerable change in the composition of the Council. He indicated that hopefully, through the Legislature, the Governor's Advisory Council will be given some statutory authority and thus, be put on a little firmer ground. The Governor's Advisory Council is made up of 51% consumers and is appointed by the Governor. It is a governing board. All policy decisions are made by the Council and implemented by the staff. He indicated that there had been implications that the authority for CHP lies chiefly in the hands of the Director of CHP and that he would like to dispel this idea. He reported that CHP would continue, as in the past, where the Advisory Council controls major policy decisions.

Dr. Kelley stated that the problem in Missouri has been (1) Inadequate funding. CHP has not been able to establish all the area agencies that it should. Eighty-five percent of the population is now in CHP local areas, but there are large geographical areas that are not covered; (2) A salary schedule that is below the national average; and (3) As a result of the salary schedule, they have difficulty in recruiting staff.

The basic premise of CHP is that the original planning should come from the local community. Problems have occurred throughout the state in getting people to cooperate within the local area. A lot of people feel that it is impossible to get a group of consumers and providers of health to cooperate as desired.

Dr. Kelley stated that, at the state level, regardless of the fact that people have different interests and different ideas of what the health system should be, it had been his experience that if you get reasonably intelligent people together and sit down and work things out, you really can achieve results. The results are somewhat meager at times, but there is some progress. If people say this is impossible at the local, regional and state level, then there is going to be federal planning. Dr. Kelley expressed a personal concern for the apathy and disinterest expressed by physicians in CHP activities.

Dr. Kelley stated that CHP had developed a task force to investigate the accessibility of health services. The group held a meeting and asked both providers and consumers what they thought the major defects were in people getting health care. One of the major defects that became apparent was the lack of any plan for emergency medical services in the state. A conference on emergency medical services was held and a state plan was developed. A state center for health statistics is being developed. It will be a center where you can go for definite information about physician distribution, dentist distribution, nursing homes, hospitals, etc.

Dr. Kelley reported that so many things were being placed in the CHP office that they may not be able to accomplish their primary purpose which is long-range planning. One of the things that has come up this year is certification of need legislation.

Dr. Kelley stated that it is difficult to get a physician interested in CHP and attend meetings. There has been concern expressed over the fact that 51% consumers were required in the A and B agencies and the task forces. It was felt that there would be lay domination of all these areas. Dr. Kelley stated that providers are listened to and physician's influence greater than numerical representation. Dr. Kelley expressed concern on what position organized medicine will take in regard to CHP.

He stated that the composition of the present Council is good. There is now better representation of practicing M.D.s and D.O.s on the Council. A dentist has been added to the Council and the consumer representation also is good.

Dr. Hetlage stated that apathy is a problem. He suggested that before the next Council meeting, a list be made of the positive things the B agencies had done throughout the state for health care. He indicated that in his area, the B agency had been mainly involved in facility review. Dr. Kelley stated that Dr. Hetlage was right in that the area agencies have been bogged down in facility review and have not taken the opportunity to get involved in actual basic health planning. He stated that he hoped to send to each member of the MSMA Council a copy of the current composition of the Governor's Advisory Council and a copy of the task force reports that have been accumulated. Dr. Kelley said

MSMA Woman's Auxiliary Celebrates 50th Anniversary

Mrs. Charles R. Willman, President *(right)*, applauds as Dr. Charles B. Wheeler, mayor of Kansas City, presents a key to the city to Mrs. Howard Liljestrand of Honolulu, President-Elect of the AMA Woman's Auxiliary.

Mrs. George J. Lytton, newly-installed President *(left)*, presents the past-president's pin to Mrs. Charles R. Willman, retiring President, during the beautifully appointed 50th Anniversary and Installation Luncheon on April 6.

The year, 1974, marked the 50th Anniversary of the Woman's Auxiliary to the MSMA. The Auxiliary celebrated the occasion with special programs, the 50th Anniversary Luncheon honoring past-presidents and publication of "50 Years of Service," a book which records the history of the Auxiliary since it was founded by Mrs. Willard Bartlett of St. Louis in 1924.

Mrs. Jordan Kelling *(left)* and Mrs. James A. Reid *(right)* "unveil" the book, "50 Years of Service," with an original skit. Miss Jean Duensing *(center)*, Managing Editor of MISSOURI MEDICINE, and Mrs. Reid assisted Mrs. Kelling in production of the book, a history of the Woman's Auxiliary.

In celebration of the 50th Anniversary, four past-presidents modelled costumes representing four decades in the history of the Auxiliary. *(Left to right)* Mrs. Keith D. Jones, the '20s; Mrs. Herbert L. Mantz, the '30s; Mrs. Henry C. Bauman, the '40s; and Mrs. Richard A. Sutter, the '50s.

Mrs. James A. Reid, Public Affairs and MMPAC Chairman, visits with Dr. John R. Chenault of Decatur, Ala., a member of the AMA Board of Trustees and guest speaker at the Auxiliary's Public Affairs Breakfast on April 6.

(Left to right) Mrs. Raymond McIntyre of Jefferson City, Mrs. William R. Cason of Clinton and Mrs. Charles B. Wheeler of Kansas City were guests at the 50th Anniversary Luncheon which featured a program entitled "Golden Reflections."

that this year a task force is in the process of organization which would be involved in home health care.

A question was asked as to whether there would be conflict between the proposed PSRO regions and the CHP boundaries. Dr. Kelley stated that the Governor's Advisory Council had not taken a position on PSRO areas. It had been suggested that the Advisory Council take over this job, but Dr. Kelley stated that this would be inappropriate because the Council is made up of 51% consumers. PSRO is involved in peer review and consumers should not be involved in peer review.

Mr. McIntyre mentioned that Dr. Kelley had stated that the subject of certificate of need legislation might come up in the state legislature and asked how this might conflict with the federal law which more or less has to do with certificate of need legislation. Dr. Kelley stated that the federal law is limited to those institutions which participated in Medicare and Medicaid. The state law, if passed, would cover any institution. Dr. Peterson asked how CHP is coming on such a state plan. Dr. Kelley stated that the CHP does not have a state plan and that one would have to be developed step by step.—Referred to Reference Committee on Resolutions.

REPORT OF COMMISSION ON PUBLIC AFFAIRS

■ Dr. Bowles acknowledged with deep regret the death of Dr. Arthur Neilson. He stated that Dr. Neilson will be missed on the Commission. Dr. Bowles said that Dr. James Denninghoff of Columbia will replace Dr. Neilson in the area of occupational health on the Commission.

Dr. Bowles stated that because of the failure to attract a good attendance, he wondered if the Public Affairs Conference is accomplishing the purpose for which it is intended. The Commission recommends that for at least one year, the emphasis of the conference be shifted to MMPAC and that it be called an "MMPAC Workshop." The Commission further recommends that the "MMPAC Workshop" be held on the first weekend in February, 1974 and that Dr. Hubert Ritter be asked to serve as Chairman for the Workshop.

A motion to accept and approve this portion of the report was made by Dr. Martin. The motion was seconded by Dr. Hetlage and carried.

Dr. Bowles stated that the Commission recommends that the Auxiliary Public Affairs Breakfast at the Annual Session be continued for 1974, but that MMPAC funds not be used to support the breakfast. Mr. McIntyre stated that he had contacted Mrs. Willman, President of the Auxiliary, about a speaker for the breakfast. The AMA has designated Dr. John M. Chenault as the Board representative to attend the 1974 MSMA Annual Session. Mrs. Willman will invite Dr. Chenault to be the speaker for the Public Affairs Breakfast.

Dr. Bowles stated the Commission recommends continued support of Regional Medical Program projects. He said that RMP has been funded through June 30, 1974.

Dr. Bowles indicated that the Commission commends those local component medical societies who are sponsoring medical aspects of sports meetings with area coaches. The Commission also recommends wide dissemination of timely news releases of interest to the public on venereal disease, immunizations, donating body organs and others.

A motion to approve the entire report was made, seconded and adopted.

Dr. Hetlage suggested that at the next annual session, a breakfast be held with the Councilors and the Presidents and Secretaries of medical societies for a general discussion of medical society problems. Dr. Hansbrough pointed out that during the annual session, the delegates usually have breakfast with their Councilors to discuss matters. Mr. McIntyre suggested that perhaps this could be done during the Public Affairs Conference in February.—Referred to Reference Committee on Miscellaneous Affairs.

■ Dr. Martin stated that he needed the names from Councilors of two people, at least one to be a physician, from each Councilor District suggested for the PAC Board. These will be given to the Nominating Committee for consideration. He indicated that they could be sent to Mr. McIntyre for transmittal to the committee.

Dr. Martin stated that he had a suggested resolution to propose:

> Whereas, The American Medical Association is now in the process of reordering its internal priorities, and,
>
> Whereas, The AMA is a federated structure, composed of state and county medical societies and,
>
> Whereas, 12 men are now expected to maintain AMA's relations with 435 Congressional Districts, 100 Senatorial Districts, 50 State Medical Associations, 50 State PACs, 50 State Legislatures and over 2,000 county medical societies, and,
>
> Whereas, We, the states, and our component county societies expect and need the American Medical Association to provide us with technical expertise which we cannot afford, and,
>
> Whereas, We are only as strong as our weakest link, therefore be it
>
> *Resolved*, That the field offices of the American Medical Association be given a top priority within the "mission" concept to assist the states and counties with more technical expertise, and be it
>
> *Resolved*, That these Regional Offices be provided with additional staff to provide much needed assistance in the areas of Communication and Promotional Development, Membership and Promotional Development and Legislative Development, all strictly for the help of these 50 component members of this federation of organized medicine.

Dr. Martin moved acceptance of this resolution for further Council study. The motion was seconded by Dr. Bradshaw and carried.

NEXT COUNCIL MEETING

Dr. Chandler reported that the next Council meeting will be held on December 14, 15 and 16 at the Ramada Inn in Jefferson City. The Budget Committee will meet at 1 PM on the 14th and the Council will have an executive-session dinner meeting on Friday night. The meeting was adjourned.

EXECUTIVE SESSION

In Executive Session following the adjournment of the regular Council meeting, the Council considered the following:

The matter of any staff member being designated as an executive officer for any specialty groups in the state was discussed. After considerable discussion, the following motion was made, seconded and unanimously adopted: "No member of the staff of MSMA is to serve as an executive officer for any specialty group, insurance group, foundation or other segment of organized medicine."

The second item discussed was a request to the AMA to provide a survey team to look at the Missouri State Medical Association. The Chairman pointed out that in such a letter of request, we need to specify certain items which we would like the survey team to study and advise upon. We believe that this survey team can assist us in evaluating our present activities and operation and can give us suggestions which will be helpful in planning the future of our Association. The following items were agreed upon for the AMA survey team to consider: review and advise us as to needed changes in our Constitution and Bylaws; our community relations or, better stated, public relations; our communications' efforts; our executive staff organization and activity; and our financial status and budget control.

Mr. McIntyre was directed to write a letter to the

AMA requesting a survey based upon these stated items.

The third item was presented by Dr. Chandler who reported that he is quite sold on a policy manual of the Illinois State Medical Society which sets forth in printed form the existing official opinions, policies and practices of the Illinois State Medical Society which may be used as reference documents by officers and spokesmen for the Medical Society as well as for information of the membership.

Dr. Chandler proposed that a similar policy manual be drafted by MSMA and kept current, so it will be available to all those needing its contents. It also was recommended that this idea of a policy manual for the MSMA be referred for consideration and further recommendation by the Committee on Planning of MSMA.—**Referred to Reference Committee on Reports of Officers.**

Meeting of December 15, 1973

■ R. Allen Chandler, M.D., Kansas City, Chairman, called the meeting to order. Those present were Drs. Chandler; E. A. Stricker, St. James; James C. Cope, Columbia; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; Walter T. Gunn, St. Louis; Lysle Bach, Hannibal; Max S. Franklin, St. Louis; Louis P. Hetlage, Troy; Robert Bregant, Jefferson City; William D. Bradshaw, Clinton; Claude Cooper, Thayer; E. T. Hansbrough, Poplar Bluff; R. A. Slickman, Kansas City; Stanley S. Peterson, Springfield; J. Loren Washburn, Versailles; Joseph White, William D. Mayer, William C. Allen, and Paul R. Young, Columbia; R. K. Noback, Kansas City; Messrs. Hollister S. Smith, St. Louis; Ray McIntyre, Tom P. Fox, Royal O. Cooper and C. C. Swarens, Staff.

Dr. Chandler called the meeting to order and requested approval of the minutes of the Sept. 29-30, 1973 Council meeting. On motion, duly seconded, the Council minutes of Sept. 29-30 were approved as printed in the December, 1973 issue of Missouri Medicine.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF THE EXECUTIVE SECRETARY

■ Mr. McIntyre indicated that Mr. Noble could not be present for the Council meeting. The briefs on both sides have been filed in the HCF suit with the St. Louis Court of Appeals. In early January, the Court will assign this case to a judge of the Court who will research the case and make recommendations to the Court. Following that, the Court will make its final decision.—**Referred to Reference Committee on Resolutions.**

■ A letter was received from the College of American Pathologists regarding their program for promoting quality laboratory services in private physicians' laboratories. This entails surveying or determining by a certain procedure of questionnaires sent out and certain standards set up to determine whether the private physicians' laboratories are of the quality they should be. This program was explained to the Council sometime ago by Dr. Blaine Hibbard. The College of American Pathologists wishes to encourage the State Medical Association to establish a Laboratory Quality Committee and to recommend the program they call PEP to its membership.

On motion, duly seconded, it was agreed that this matter be given to the appropriate Commission at the discretion of the Chairman of the Council for report back to the Council.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Mr. McIntyre then referred to a request Dr. Hetlage had made regarding contacting the Osteopathic Association to get their policy on D.O.s attending medical meetings. The Osteopathic Association was contacted and the reply has been turned over to Dr. Hetlage.—**Referred to Reference Committee on Resolutions.**

Dr. John N. Martin of St. Joseph *(left)* and Dr. Robert E. Bregant of Jefferson City were reelected as Councilors of the First and Fifth MSMA Councilor Districts, respectively.

REPORT OF THE TREASURER

■ Dr. Judd presented the Treasurer's report. He reviewed the figures shown in the Treasurer's account minus the accounts payable, which left a balance on hand of $71,676.06 as of Dec. 1, 1973. This does not include the investment account (at cost) of $81,354.07.

On motion, duly seconded, the Treasurer's report was approved.

BUDGET COMMITTEE REPORT

The Budget Committee met on Friday afternoon, Dec. 14, 1973 prior to the Council meeting on Saturday. The Committee reviewed the material presented which showed Exhibit A—Actual Income through Oct. 31, 1973; Expected Total Income for 1973; Income Budget for 1973 and Estimated Receipts for 1974; Exhibit B—Actual Expenditures through Oct. 31; Estimated Expenditures for 1973; Budget for 1973 and Proposed Budget for 1974; Exhibit C—Actual Meeting and Committee Expenses through Oct. 31, 1973; Estimated Expenses for all of 1973; Budget for 1973, and Proposed Budget for 1974. A breakdown of anticipated income and expenses for the years 1973 and 1974 also was included.

Dr. Judd indicated that at the last meeting of the House of Delegates, it was proposed that some money be spent on the educational aspects of MMPAC. This might include preparation of brochures, mailings, postage and part or full time use of a secretary. The Committee suggested the figure of $3,000 for this purpose. Dr. Judd indicated that he would like to point out to the House there has been a response to their request.

Dr. Judd further reported that the Committee recommends setting aside money for the Council to use during the year for certain things that are important for the Council, such as bringing in a particular speaker, etc. This money would be set aside to be used on request of the President or Chairman of the Council and such use would be reported back to the Council at the next meeting. The figure of $5,000 was recommended for this purpose.

Including the $3,000 and $5,000 items mentioned above, this would give a total budget for 1974 of $367,523. As compared to the estimated receipts for 1974 of $355,675, this would be a deficit of $11,848.

Dr. Judd then requested permission of the Council to contact the Missouri State Medical Foundation (student loan program) and request some financial support from the Foundation. He stated that in the past, the MSMA has supported the Foundation with an assessment. We have provided them with the part-time services of Mr. Fox and a secretary. Dr. Judd proposed that a reasonable and conservative estimate would be that about 30% of their total salaries might be recovered from the Foundation. This would give MSMA an additional $6,600. Subtracted from the $11,848, that would leave a total deficit of $5,248.

The Budget Committee approved the following proposed budget for 1974:

Salaries	$136,198
Furniture and Fixtures	750
General Expense	3,700
Office Supplies	5,000
MSMF Assessment	39,870
Journal Expense	40,000
Postage	6,000
Equipment Rentals and Repairs	4,000
Telephone and Telegraph	8,000
Pension Expense (Insurance and Retirement)	21,500
Legal and Professional	10,000
Payroll Taxes	6,250
Commission-Committee Meetings	35,600
Annual Session	22,000
Taxes—I.R.S.	1,800
Travel Expenses	6,000
Building Expenses	12,855
MMPAC Educational Funds	3,000
Council Special Contingency Fund	5,000
TOTAL	$367,523

On motion of Dr. Hetlage, duly seconded, the report of the Budget Committee was accepted, including those specific recommendations of Dr. Judd relative to Council expenses and to the payment of portions of the services by the Foundation and, further, to instruct Dr. Judd to proceed with further developments to utilize the funds for MMPAC.

Discussion then followed regarding the decrease in Journal advertising and who might be approached regarding such. Mr. Swarens indicated that in the past two months, many letters have been written to banks, investment companies, leasing firms, etc. explaining what our Journal has to offer. We have received some replies showing interest. However, no commitments have been made. Mr. McIntyre then explained how we receive most of our advertising through an advertising bureau which handles the layouts, contracts, etc. The Bureau has certain standards set up regarding the type of advertising it will accept for its 35 medical journal members.

REPORTS OF DISTRICT COUNCILORS

District #3—Dr. Franklin said that election of officers was held for the St. Louis Medical Society with the following results: Dr. August W. Geise—President-Elect; Dr. Francis X. Lieb—Vice President; and Dr. Carol F. Williams—Secretary. Installation of officers will be held on January 5, at which time Dr. Richard V. Bradley will be installed as President of St. Louis Medical Society.—**Referred to Reference Committee on Reports of Officers.**

■ The Council of the St. Louis Medical Society approved the Blue Shield Panel Plan since it has been revised.—**Referred to Reference Committee on Resolutions.**

■ The State Board of Healing Arts recently held a three-day examination in the St. Louis Medical Society Building.

Dr. Franklin stated that *St. Louis Medicine,* the Society's Journal, has modified and improved its appearance.

Dr. Franklin reported that the St. Louis Medical Society with the First National Bank of St. Louis is working on a plan to be able to transfer dues once weekly if the State Association will approve this type of action. Mr. Hollister Smith reported that some other societies are doing this. He stated, however, that it could not be done in 1974. It is felt that this could definitely shorten the time span between the time a physician pays his dues to the county and they are submitted to MSMA and then on to the AMA. In this manner, the bank could send dues directly to MSMA and to AMA on a regular schedule.

On motion, duly seconded, the Council approved St. Louis Medical Society's implementation of this plan.

Dr. Franklin stated that he had received a letter from a physician seeking approval for use of credit cards for patients to pay their physician. He said many physicians are now doing this and the AMA has approved it. A letter will be sent indicating this to the physician.—**Referred to Reference Committee on Reports of Officers.**

■ *Resolution #9*—"Health and Hospital Insurance for Newborn," which was passed by the 1973 MSMA House of Delegates, was brought up and the St. Louis Medical Society feels that this should be carried out. The Pediatric Association of Missouri will prepare such legislation and the St. Louis Medical Society Council hopes that the State Council will back it. Dr. Matthews stated that there is such a proposed bill and the Legislative Committee would be considering it at their luncheon meeting.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ *District #5*—Dr. Bregant reported that the Fifth District has been primarily trying to educate every physician within the area regarding the Foundation concept.

District #10—Dr. Hansbrough reported that the physicians in his area recently received the papers which, when signed, will officially make them members of the Southeast Missouri Health Care Foundation. The Foundation expects to be in business soon. Many carriers are interested in submitting policies and, of course, the insurance programs must be approved. Dr. Hansbrough indicated that the Board of Directors of the Southeast Missouri Foundation are all physicians.

Discussion followed regarding the Southeast Missouri Health Care Foundation and concern was voiced over the possibility that an organization such as UNIMED, who set up the SEMHCF, might become quite powerful if it set up many foundations.

Dr. Hansbrough explained that UNIMED is under a yearly contract, which means that the Board of Directors of the Southeast Missouri Heart Care Foundation can decide, on a yearly basis, that they no longer need the services of UNIMED. It is anticipated that they will help administer the Foundation from two to three years.

Dr. Hansbrough indicated that he was concerned about the National Association of Foundations being a threat to medical societies and private practitioners.

District #9—Dr. Cooper stated that the societies of his district have been concerned about legislation that has been passed and some that is about to be passed. Attendance at the medical meetings is growing and he plans to meet with all of his societies in the near future.

District #8—Dr. McAlhany stated that he had no formal report for the Council.

District #4—Dr. Hetlage reported that a great deal of discussion on PSRO was held during his district conference. The general feeling was that education is very important and Dr. Hetlage hopes to have a conference in his district in early spring for educational purposes regarding PSRO. Their feeling was one of at least minimal cooperation until they see what the regulations will actually show.—**Referred to Reference Committee on Resolutions.**

■ Dr. Hetlage said that he had received a letter from Dr. Allen Klippel, including a status report of the Emergency Medical Services Committee. They are trying to develop an EMS Plan for Missouri with these ideas: seat belt law; ambulance design and training of EMTs; state communication authority to control EMS radio frequencies; categorization of hospitals in those areas of two or more institutions; and map a system of transport and referrals.

Discussion followed regarding the development of this EMS Plan and some of the items to be included in it. The Council Chairman indicated that in order to clarify some of these points, he would extend an invitation to Dr. Klippel to attend the next Council meeting.

Dr. Hetlage stated that rural ambulance service is in a state of turmoil at present. However, the legislation has made people realize that something must be done and some areas are voting for ambulance districts.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ Dr. Hetlage indicated that a reply had been received from the Missouri Association of Osteopathic Physicians and Surgeons regarding its policy concerning its members attending medical society meetings. He read portions of the letter from the Osteopathic Association indicating that its members are not discouraged from attending medical society meetings for educational purposes. Dr. Hetlage recommended that we should encourage osteopathic participation in the scientific portions of the meetings, but not solicit them as members.

He said the Blue Shield Open Panel Program, as modified, has been accepted by both St. Louis County Medical Society and the St. Charles-Lincoln County Medical Society.

Dr. Hetlage stated that he felt that areas of medical care in the state that need investigation should be brought to the attention of the Council and appropriate action taken. He stated his concern over the deplorable conditions that exist in some of the nursing homes in the state and feels this is one of the major problems.

The Chairman indicated that there is a state agency responsible for nursing homes. Anytime a physician sees these conditions in a nursing home, he should report it to that agency.

Dr. Allen stated that the state law regarding nursing homes indicates that homes do come under it if they have three or more people for whom they are providing care. Sometimes, it is difficult to define whether or not care is being provided. The local prosecuting attorneys in some instances do take action against some of these homes.

Dr. Matthews said that he felt some type of day care system might work if the individuals had relatives who could look after them at night.

Dr. Hetlage further reported that he felt that there should be some way to keep the general public informed regarding what their benefits are under Medicare, particularly in regard to extended care facilities, and that, possibly, some pressure might be put on Congress. He suggested that this might be referred to the Commission on Medical Economics. However, the Chairman stated it might be well for the Division of Health to give us an up-to-date report on this.

District #2—Dr. Bach stated that they have been inviting D.O.s to their meetings for some time, it is working out nicely and no pressure is being put on them to join the society.

Dr. Bach said they had the president of UNIMED talking with them and UNIMED was given instructions to proceed with the organizational phase of a local foundation. —**Referred to Reference Committee on Resolutions.**

■ Negotiations are now going on with the local Junior College regarding training laboratory technicians for an appropriate degree. This is on a regular tuition basis.

Dr. Bach reported that one of the hospitals is presently trying to set up a pediatric intensive care unit and he would report more on this at a later date.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ *District #7*—Dr. Chandler reported that Dr. Fred Fowler has recently taken over the duties as President of Jackson County Medical Society. Dr. Warren Wilhelm is President-Elect.

The Jackson County Medical Society building is going to to completely refurbished.—**Referred to Reference Committee on Reports of Officers.**

■ Jackson County held an educational meeting on PSRO and had a very good turnout of approximately 300 members. Three groups, including UNIMED, are now under consideration to handle the organizational problems in Jackson County. No decision has been made as to which one will be used.

Dr. Chandler stated that they have had some trouble with MARC (Mid-American Rescue Commission) in that their board had no medical representation, but only in an advisory capacity. At the insistence of Jackson County Medical Society, they now have some representation on the Board. Dr. Chandler said that sometimes in dealing with these agencies, it is necessary to take a firm stand.—**Referred to Reference Committee on Resolutions.**

■ The Chairman indicated that Dr. John Martin of St. Joseph was hospitalized and could not be present at the meeting.

District #6—Dr. Bradshaw had no formal report for the Council.

REPORT OF THE PRESIDENT

Dr. Stricker reported that he had participated in a 30-minute television program recently in Springfield regarding the Dr. Finch licensure situation.

The President stated that he had attended the AMA Clinical Session in Anaheim. During the AMA's full day program on PSROs, the presidents of state medical associations had a special program. They also had an extensive panel on HMOs.

Dr. Stricker attended the Grand River Medical Society Christmas Party on December 13 and said that it was a very nice affair.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF COMMISSION ON MEDICAL-LEGAL AFFAIRS

■ The Commission on Medical-Legal Affairs met on November 3. Dr. Irving Clark presented four proposals by various brokers for a group professional liability insurance program for MSMA. After his summarization of the plans, the physicians present adopted the following motion:

> It is recommended that an attorney specializing in insurance be obtained to evaluate the Missouri malpractice situation, to determine a solution and to conduct a feasibility study of a group professional liability insurance program for MSMA.

On motion of Dr. Hansbrough, duly seconded, the report of the Commission on Medical-Legal Affairs was accepted and the Commission to move as rapidly as possible on this.

REPORT OF COMMITTEE ON CONSTITUTION AND BYLAWS

The Committee on Constitution and Bylaws held a telephone conference call on December 11 with all members participating. The first item for discussion concerned Resolution #13. At the 1973 Annual Session, the MSMA House of Delegates adopted the report of the Reference Committee on Constitution and Bylaws concerning Resolution #13. It was pointed out that because the Speaker and Vice-Speaker are not elected at the same time as other Delegates, it would be possible to have either the Speaker or the Vice-Speaker not elected as delegates with the result that the House of Delegates would be without these officers. The Reference Committee recommended that the

Constitution be changed to provide that the Speaker and Vice-Speaker shall serve as delegates-at-large.

> The Committee recommends that Article IV of the Constitution be amended by inserting a comma following the word "Association" and adding the following words "the Speaker and Vice-Speaker." This sentence would then read, "The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker, who will serve as delegates-at-large."

The Committee also suggests that if the change in the Constitution is adopted, a corresponding change be made in the Bylaws. Chapter III, Section 2 of the Bylaws should be amended by inserting a comma and the following words "the Speaker and Vice-Speaker" following the word "Association" in the last sentence. The sentence would then read, "All Past-Presidents of the Association, the Speaker and Vice-Speaker shall serve as delegates-at-large."

Again, it is emphasized that this change is recommended because it is conceivable that the Speaker or Vice-Speaker of forthcoming Annual Sessions would not be elected as a delegate by his component society and the MSMA Constitution stipulates that the Speaker and Vice-Speaker must be elected from the body of the House of Delegates.

Dr. Whitener noted to the Committee that held over until the 1974 Annual Session is the constitutional amendment recommended by the Committee on Constitution and Bylaws and adopted by the House of Delegates at the 1973 Annual Session. This proposed amendment to the Constitution will be voted on at the 116th Annual Session in April, 1974. The amendment reads as follows:

> "Petition signed by 10% of the active members of the Association, including petitioners representing at least one half of the component Medical Societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question."

On motion of Dr. Franklin, duly seconded, the report of the Committee on Constitution and Bylaws was accepted by the Council.—**Referred to Reference Committee on Constitution and Bylaws.**

REPORT OF THE COMMISSION ON CONTINUING EDUCATION AND HEALTH MANPOWER

■ The Commission on Continuing Education and Health Manpower, George H. Ladyman, M.D., Chairman, met on November 11.

The Ad Hoc Committee on 116th Annual Session presented a progress report indicating that specialty organizations are sponsoring a total of twenty-five 90-minute sessions. The opening session on Friday, April 5, will feature PSRO. The anesthesiologists and the surgeons are planning to cosponsor a program on emergency medical services.

Dr. Worley, Chairman of the Ad Hoc Committee on Health Manpower, reported that they received requests of the professional state nursing organization for guidelines relating to emergency lifesaving services which are sometimes required of a nurse when the physician is not present. Following extensive negotiations with the registered nurses, including advice from the related medical and surgical specialties, the Ad Hoc Committee recommends as follows:

I. *Intracardiac Drugs*

A. In those areas of special intensive care units and cardiac care units, where Registered Professional Nurses have had special educational and clinical preparation and possess the necessary skills, and the physician not being available, the nurse, if so designated, may inject medication into the heart, where cardiac standstill is recorded per monitor.

B. Registered Professional Nurses who do not have special preparation as above may not administer intracardiac medications.

II. *Endotracheal Intubation*

A. Registered Professional Nurses do not do endotracheal intubation in medical centers or hospitals where other persons such as physicians and anesthesthesiologists are available within a short period of time.

B. In areas of the state where a physician would not be available and a Registered Professional Nurse is designated as the skilled person in the institution to perform endotracheal intubation, that the nurse be trained by an anesthesiologist or a certified nurse anesthetist; and that the nurse so designated be required to practice this technique once a week or sufficiently frequently to maintain competence in this procedure.

During the Commission meeting, it was moved, seconded and voted unanimously to approve both guidelines as written.

Discussion followed regarding the report of the Ad Hoc Committee on Health Manpower. It was suggested that the first phrase in I. Intracardiac Drugs A. be removed. This paragraph would then read as follows: "A. Where Registered Professional Nurses have had special educational and clinical preparation and possess the necessary skills, and the physician not being available, the nurse, if so designated may inject medication into the heart, where cardiac standstill is recorded per monitor."

The motion was made, seconded and approved that these guidelines be accepted as amended, omitting the first phrase, "In those areas of special intensive care units and cardiac care units," and that copies of these guidelines be sent to the Missouri Hospital Association, the Osteopathic Association and the various nursing organizations.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORT OF AMA DELEGATES

■ Dr. Stanley Peterson reported on the highlights of the AMA Clinical Session held in Anaheim, Calif., on December 1-5. He indicated that both the December 10 issue of *American Medical News* and *AMA Newsletter* contain a good rundown on the various items discussed and acted upon at the AMA Meeting. Many of these actions also will appear in the News Insert of the January issue of Missouri Medicine.

Dr. Peterson indicated that Mr. Nathan Stark, Vice-President of Hallmark, will receive the AMA's Layman's Citation for Distinguished Service at the June AMA Annual Session. Dr. Peterson stated that he felt MSMA should take steps to recognize this gentleman during our 1974 Annual Session in Kansas City and, certainly, see to it that he is taken care of at the June AMA Meeting.

All Delegates and Alternate Delegates were present at the meeting, in addition to the President and President-Elect. Missouri had a good hospitality room.

Dr. Peterson stated that he felt that Missouri has arrived at a point at AMA meetings where people know we are there and we are receiving recognition accordingly.

Dr. Vernon Wilson is on the Council on Medical Education of AMA. Dr. Joseph White, new Provost for Health Affairs at the University of Missouri-Columbia, also is on this Council on Medical Education and up for reelection this year. He was elected to that Council from the state of Texas. It was Dr. Peterson's feeling that we should support Dr. White for reelection to the Council on Medical Education.—**Referred to Reference Committee on Reports of Officers.**

■ Much discussion centered around PSRO at the AMA Clinical Session. The House of Delegates approved a PSRO policy, pointing out that the best interests of the American people would be served by repeal of the legislation. The policy also continues support of AMA activities to provide constructive amendments to the law and the AMA efforts to develop appropriate regulations for PSROs. It calls upon the House of Delegates, as individual physicians and through the Board of Trustees, to inform the public and legislators of the "potential deleterious effects of this law on the quality, confidentiality and cost of medical care."

REPORT EE-PSRO

Dr. Chandler stated that we had been contacted by AMA and had been asked what our position on PSRO is and whether or not we would work for repeal. Dr. McAlhany stated that he doubted that we could suggest to Congress that a law be repealed which has not been tried. He indicated that, perhaps, we should study the law and make certain recommendations in regard to amending it. Dr. McAlhany mentioned several sections in PL 92-603 that MSMA could work toward having changed.

Dr. Bradshaw stated that he objected to the nonparticipation parts in Report EE—Paragraph 3, Page 2 and Paragraph D, Page 3, which read as follows:

> "(3) Non-participation can be interpreted in several ways. Nonparticipation by constituent and component medical societies refers to the unwillingness of such societies to cooperate in the development of PSROs. Nonparticipation by individual physicians implies unwillingness to provide professional reimbursable services for Medicare and Medicaid beneficiaries. In general, non-participation by organized medicine in the development of PSROs would be an abrogation by the profession of its responsibility to the public and the profession to assure that monitoring of the quality and cost of medical care is professionally oriented. Regardless of participation or nonparticipation by physicians or medical organizations, no physician can escape review of his Medicare and Medicaid services as long as the law remains in force."
>
> "(D) To suggest nonparticipation by all constituent and component societies. Such nonparticipation would specifically refer to the establishment of a PSRO by a unit of organized medicine."

Dr. Bradshaw stated that we have to be law abiding citizens, but we can work for repeal. Dr. Bradshaw moved that Paragraph 3, Page 2 and Paragraph D, Page 3 be omitted and the Council then favor the report of the Board of Trustees and the Council on Medical Service with those omissions. A motion was seconded by Dr. Hansbrough and adopted.

Dr. Peterson stated that nonparticipation is a possibility under the law. It was pointed out that the question the AMA had asked was about our position concerning repeal of the PSRO law and whether or not we would be willing to work for repeal.

A motion was made by Dr. Bradshaw that the Council believes that the PSRO Law should be repealed or effectively amended and we will work actively with the Missouri Congressional Delegation to this end. The motion was seconded followed by discussion.

Dr. Matthews stated that there isn't much chance for repeal. We should direct ourselves to amending or modifying the law to conform to something we could live with. After discussion, the vote was to approve Dr. Bradshaw's motion. —Referred to Reference Committee on Resolutions.

REPORT OF AD HOC COMMITTEE ON CME

■ Dr. Paul Young stated that the Council had an outline of the proposed Continuing Medical Education program for MSMA. The Committee has developed an educational plan for the membership which is voluntary in nature and which should achieve certain objectives which are outlined in the proposal. He indicated that a proposed budget was attached to the report.

Dr. Young stated that there is a variety of things going on in other states in regard to CME. He indicated that the committee developed an educational program which is voluntary and which could respond to local needs. The State Medical Association would provide the personnel and expenses to carry this out. Dr. Young reported that the standards for this program were being developed by each specialty on our Interspecialty Commission.

Dr. Bradshaw stated that the report was excellent, but he wondered if the committee had considered adding lay people in health related fields to this program. Dr. Young stated that the committee had discussed this, but it was not included in the proposal. He indicated that the committee would pursue this matter if the Council wishes.

A motion was made to accept the report with commendation. The motion was seconded and carried.

Dr. Bradshaw moved that the scope of the committee be enlarged to include lay education in health matters. The motion was seconded by Dr. Hetlage and carried.—Referred to Reference Committee on Medical Education and Public Welfare.

REPORT OF THE PLANNING COMMITTEE

■ Dr. Cope reported that the Planning Committee recommends that the MSMF assessment be continued for another three years and it also recommends that the interest structure for loans be changed as follows: 2% interest rate to day of graduation from medical school; 5% interest rate for the next two years; 8% interest rate thereafter. It was felt that by raising interest rates, the principal would be paid back faster.

A motion was made to adopt recommendation #1. The motion seconded and carried.

The Planning Committee recommends that a policy manual be developed that would give in concise form policy statements that MSMA has on various issues.

A motion was made by Dr. Hetlage to accept this recommendation. The motion was seconded and carried.

Dr. Cope stated that the Planning Committee feels that some type of recognition should be developed for our members who serve on Committees, Commissions, as Councilors, Officers and AMA Delegates and Alternate Delegates.

A motion was made, seconded and carried to accept this recommendation.

A question was asked as to what type of recognition this would be. It was pointed out that this had not been worked out.

Dr. Hetlage moved that in accepting the above recommendation that this recommendation be returned to the Planning Committee for further implementation and recommendation. The motion was seconded and carried.

Dr. Cope stated that MSMA needs to make its members aware that they are members and that the Association needs to reach more members. The Planning Committee recommends that two field secretaries be hired and, also, one additional office secretary. Hopefully, these field secretaries will be able to contact every member twice a year and explain issues that are before physicians and keep the membership better informed of what is going on.

The Planning Committee also recommends that funds be made available for Councilors to use in communicating with their district members. The Committee also recommends raising MSMA dues and assessment dues to a total of $100; which would consist of $90 in dues and the $10 MSMF assessment. This dues increase would be necessary to accomplish the above recommendations as well as to provide funds for Dr. Young's continuing medical education program.

The Planning Committee recommends that the Association move into various areas of service for the membership. These services could include such things as automobile leasing, developing our own professional liability insurance company group, etc.

Dr. Cope indicated that approval was needed for the above recommendations. Dr. Hetlage pointed out that this whole report would go to the House of Delegates for its consideration and approval. Dr. Cope stated that this program, including the dues increase, should go to the House as a unit. In order to carry out these recommendations and Dr. Young's CME Program, the additional funds will be necessary.

A motion was made to accept the proposed recommendations. The motion was seconded and carried.

A motion was made to accept the report in toto. The motion was seconded and carried.—**Referred to Reference Committee on Reports of Officers.**

■ The Chairman of the Council presented a resolution submitted by Falls B. Hershey, M.D., St. Louis County, and informed the Council this would be referred to the Committee on Planning for study.—**Referred to Reference Committee on Constitution and Bylaws.**

LEGISLATIVE COMMITTEE REPORT

■ Dr. Matthews stated that there are 30 to 35 bills related to medicine already prefiled. Dr. Matthews mentioned several bills that had already been approved for drafting, introduction and full support of MSMA. These include a so-called "sick doctor bill." This proposed legislation has had good coverage in medical society journals and the state association journal had an article on it. A lab licensing bill has been prefiled. This bill would standardize laboratories throughout the state. A physical therapy bill also has been prefiled. A delegation amendment bill also has been prefiled. This bill would allow physicians to delegate tasks to trained assistants.

A motion was made, seconded and carried to approve this section of the report.

Dr. Matthews stated that a bill has been proposed and drafted by the Board of Healing Arts, but has not yet been introduced. He indicated that this was for information only.

A patient's or inmate's rights in human experimentation bill has been prefiled.

The Governor is proposing a mental retardation bill. This bill would increase clinics, try to identify high-risk patients and provide services to children born with a high risk of developing mental retardation. This would be administered by the Division of Health. Dr. Matthews stated that a copy of the bill had been sent to the pediatric and ob-gyn sections for review. Dr. Matthews stated that the committee felt that we should take no position until we get input from pediatrics and ob-gyn.

Several bills have been introduced which would repeal certain sections of the ambulance bill that was passed by the Legislature last session.

A motion was made by Dr. Hansbrough that we oppose the attempt to repeal the ambulance bill. The motion was seconded and carried.

A bill for the licensing and practice of acupuncture is being proposed. Dr. Matthews stated that the MSMA had taken the following position in regard to acupuncture:

> "*Resolved,* that the Missouri State Medical Association urge the Missouri State Board of Registration for the Healing Arts to utilize such legal and statutory powers as may be available to declare that the principles apparently involved in the practice of acupuncture and shiatsu are medical principles and that acupuncture and shiatsu, if found to be scientifically valid and medically beneficial, would fall under the definition of the practice of medicine."

Dr. Matthews stated that, perhaps, the Council also would like to adopt the Wisconsin statement on acupuncture which is as follows:

> "The use of acupuncture to relieve pain and provide anesthesia for patients is an experimental medical procedure. Its use must be limited to licensed physicians and surgeons. It is strongly recommended appropriate training and technical expertise be acquired by the physician before attempting its use.
>
> The physician must utilize his professional training and experience in determining the use of acupuncture for a patient only after a complete medical workup and the establishment of differential diagnosis of the patient's complaint.
>
> It is recommended that the patient further understand that acupuncture is an experimental procedure at the present time, and that no guarantee can be or is made as to the success of this form of therapy, and that alternate forms of therapy, and the likelihood of their success in the treatment of their condition should be explained to them."

Dr. Franklin moved that we add the Wisconsin acupuncture statement to ours. The motion was seconded and carried.

A motion was made to adopt the above portions of the Legislative Report. The motion was seconded and carried.

Several insurance bills are in the Legislature. One calls for insurance coverage for newborns. This would increase premiums approximately $3 to $6 per year per family unit.

A motion was made by Dr. Franklin, seconded and carried to accept this.

There is a bill calling for mental health coverage in insurance policies. This would increase premiums $25 to $40 per family per year. This bill has strong support from the Missouri Psychiatric Association. Dr. Franklin moved that we favor this. The motion was seconded by Dr. Gunn and carried.

A bill calling for dental coverage in insurance policies is proposed. This bill would provide for payment of oral surgery. No action was taken.

There also is a bill calling for elimination of coordination of insurance benefits. Dr. Hetlage moved that we favor a bill for repeal of coordination of benefits. The motion was seconded by Dr. Hansbrough. The motion was not adopted.

A psychologist's licensing bill has been prefiled. Dr. Matthews stated that the psychiatric association was looking this bill over. A motion was made, seconded and carried that we support this bill if the psychiatrists approve it.

Several other bills that have been prefiled include a pharmacists bill, a bad physical therapy bill and several fireworks bills. A bill providing for education of medical students is proposed. The state would give $100,000 to 20 medical students to help finance their education. Dr. Matthews stated that the committee had taken no position on this.

A glue-sniffing bill and a bill providing for immunity from liability for peer review chiropractors have been filed.

An abortion-right to life amendment has been filed. The committee felt that we should stay with our stand on abortion.

There is a section in the state reorganization bill that calls for Missouri University to take over the Missouri Institute of Psychiatry and, also, a section regarding the licensing board. A motion was made to accept this portion of the report. The motion was seconded and carried.—**Referred to Reference Committee on Miscellaneous Affairs.**

MSMA-SPONSORED TOURS

■ Mr. Cooper reported that our Rhine Escape was held in October and it was very successful. Dr. Matthews stated that the scientific presentations during the trip were outstanding.

Mr. Cooper indicated that we had previously approved two trips for 1974: a 15-day European trip with INTRAV in June and 8-9 day Grecian trip with Marriott in August. Marriott has been selected as the AMA official travel agency. Mr. Cooper asked that another trip be considered for 1974. The proposed trip would be an 8-day trip with Marriott to Barbados in November.

A motion was made, seconded and carried to accept this proposal.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REMARKS OF THE SPEAKER OF THE MSMA HOUSE OF DELEGATES

■ Dr. Slickman asked that the Councilors remind their component medical societies to please get their resolutions for the handbook in to the MSMA office by February 10 or by the latest, February 18. With the new bylaws change adopted at the last session of the House, resolutions that are not in the handbook must be made available to the House of Delegates 24 hours before the session in which they are to be introduced.

Dr. Slickman also indicated that he would appreciate it if the Councilors would ask the chairman of each of their county medical society delegations to send in names of suggested delegates to serve on reference committees to either him or Mr. McIntyre as soon as possible.

Dr. Slickman stated that he would ask each county medical society delegation at the Annual Session to appoint a person to poll the delegates in their delegation in order to make voting during House sessions proceed more quickly and accurately.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF DEANS

■ Dr. Mayer reported that M.U. was in the middle of admission season. The number and quality of the applicants is increasing and about one-half of the freshman class has been accepted.

Dr. Mayer stated that he would like to speak about the Missouri Institute of Psychiatry. Missouri University was asked to assume responsibility for the Missouri Institute of Psychiatry. He stated that there was a report that this would be done under the new state reorganization plan.

Dr. Mayer stated that he had just returned from the Executive Council meeting of the Association of Medical Colleges. Several pieces of medical legislation will expire on June 30, 1974. He indicated that there might be a piece of legislation that would require medical schools to charge tuition at a rate that it costs them to educate medical students.

Dr. Noback reported that the Canadian Government had issued a physician distribution report. It contained fairly realistic data.

Dr. Noback reported that they would again have students in family practice preceptorships. The quarterly proficiency examination is working well. The test covers a wide range of information. Parts of the examination have been of interest to different groups of medicine as a self-assessment tool.

Dr. Noback reported that qualifications, both personal and academic, of applicants for medical school are increasing. Construction of the Truman Medical Center, which is the replacement for General Hospital, began in October. The construction project is totally funded and should be completed in about 28½ months. The Medical School Building is nearing completion and it is hoped that it will be finished by May 15, 1974.

Dr. and Mrs. Leo H. Pollock of Kansas City attended the Annual Session. Dr. Pollock has written the popular "Missouri Medicine in Review" page for Missouri Medicine for many years.

The Area Health Education Center program is developing. The allied health component has brought in staff and has an educational program. Pharmacists had students in preceptorships.

Dr. Noback stated that the medical school invited the Liaison Committee on Medical Education to visit the school again. He indicated that he thought it wise to have the group back sooner than needed, so that they could be brought up to date on the programs at the school. Additional faculty members have been added at the medical school.

Preliminary discussion has been held with the Johnson Foundation for support to extend the care outreach of the docent teams at General Hospital. They would like the teams to extend outside the hospital hill area.—**Referred to Reference Committee on Medical Education and Public Welfare.**

MMPAC WORKSHOP AND LEADERSHIP CONFERENCE

■ Mr. Swarens reported that the MMPAC Workshop has been scheduled for Saturday, Feb. 2, 1974. This will be a work session. The AMA Leadership Conference will be held on February 23 and 24, at Ramada Inn in Jefferson City. The program deals with society leadership, public speaking, etc. and is limited to 40 people. A Practice Managament Workshop for residents will be held on May 6 and 7.

The Chairman mentioned that Dr. Bradshaw had recently been elected Chairman of the State Board of Health.

Dr. Hetlage asked if it would be possible, if a dinner or breakfast meeting could be held during the MMPAC Workshop at which people at the Workshop could meet with the Council and have a roundhouse discussion. They would be able to ask questions about various matters.

A motion was made by Dr. Bradshaw to have such a luncheon meeting. The motion was seconded by Dr. Hetlage and carried.

NEXT COUNCIL MEETING

The next Council meeting will be held on Friday, Feb. 1, 1974 at the Ramada Inn in Jefferson City. The Council will hold an executive dinner meeting on Thursday evening, January 31.

The meeting was adjourned at 4:30 PM.—**Referred to Reference Committee on Reports of Officers.**

Meeting of February 1, 1974

R. Allen Chandler, M.D., Kansas City, Chairman, called the meeting to order. Those present were Drs. Chandler; E. A. Stricker, St. James; James C. Cope, Columbia; John I. Matthews, Jefferson City; Walter T. Gunn, St. Louis; R. A. Slickman, Kansas City; John N. Martin, St. Joseph; Lysle Bach, Hannibal; Max S. Franklin, St. Louis; Louis P. Hetlage, Troy; Robert Bregant, Jefferson City; William D. Bradshaw, Clinton; Howard McAlhany, Springfield; Claude Cooper, Thayer; E. T. Hansbrough, Poplar Bluff; Stanley S. Peterson, Springfield; J. Loren Washburn, Versailles; William C. Allen, Columbia; Robert Felix, St. Louis; Herbert R. Domke, Jefferson City; Allen P. Klippel, St. Louis; Marcy A. Goldstein, St. Louis; Mrs. Charles Willman, St. Joseph; Mrs. George Lytton, Kansas City; Messrs, Herbert C. Strohson, Denver, Colorado; Lee E. Mortenson, Chicago, Ill.; Hollister S. Smith, St. Louis; Gary L. Schnedler, Springfield; Ray McIntyre, Tom P. Fox, Royal O. Cooper and C. C. Swarens, Staff.

■ Dr. Chandler called the meeting to order and requested approval of the minutes of the Council Meeting on December 15. On motion, duly seconded, the Council Minutes of the Dec. 15, 1973 meeting were approved as published.

REPORT OF THE TREASURER

In the absence of the Treasurer, the Executive Secretary gave a short Treasurer's Report indicating that the auditor's report for 1973 will show an excess of income over expenses. This financial report will be published in the March issue of Missouri Medicine and also will appear in the Delegates Handbook. Two reasons for the excess of income over expenditures were that the investment fund for the Employees' Pension Plan required less cash outlay and, also, there was a reduction in the cost of publishing the Journal due to less advertising.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF THE EXECUTIVE SECRETARY

■ Mr. McIntyre indicated that the Health Care Foundation law suit will be heard by the St. Louis Court of Appeals on March 4. There will be no witnesses other than the Legal Counsel for both sides.—**Referred to Reference Committee on Resolutions.**

■ On the Employees' Pension Plan, there are three trustees who, according to the Bylaws of the Pension Plan, are authorized to operate the Plan. Presently these three trustees are Dr. Franklin, Mr. Noble and Mr. McIntyre. We have received a letter of resignation as trustee from Mr. Noble and this vacancy should be filled.

On motion, duly seconded, it was agreed that Dr. John I. Matthews would become a trustee of the Employees' Pension Plan.

On motion, duly seconded, it was agreed that a letter of appreciation be transmitted to Mr. Noble for his services over many years.

Mr. McIntyre indicated that it was time to appoint or reappoint an Editor to Missouri Medicine.

On motion, duly seconded it was unanimously agreed that Dr. Joseph V. Finnegan be reappointed as Editor of Missouri Medicine.

Mr. McIntyre said that Dr. Finnegan will be requested to attend the Council Meeting on April 3 to present his recommendations for the Publications Committee and the Editorial Board.

Dr. Cope asked if there might be some merit in also having an Associate Editor for Missouri Medicine and asked that the Council consider this possibility.

A motion was made and seconded that a letter be sent to the AMA Board of Trustees endorsing Dr. Joseph White for reelection to the Council on Medical Service. The motion carried. It was pointed out that this letter should be sent during the month of February.

Mr. McIntyre stated that the AMPAC Workshop will be held in Washington, D. C., on March 15-17, 1974. He said that it has been our policy to have a luncheon for our Congressional Delegation. He requested authority to again have this luncheon this year.

On motion, duly seconded, it was agreed that the luncheon for our Congressional Delegation be held again this year during the AMPAC Workshop and that adequate funding be provided.—**Referred to Reference Committee on Reports of Officers.**

■ Mr. McIntyre called the Council's attention to the statement made by Russell B. Roth, M.D., President of the AMA, at a press conference on January 25 pertaining to proposed HEW regulations which would require preadmission certification for Medicare and Medicaid hospital patients. Staff had drafted a proposed letter to be sent to HEW indicating our full opposition to their proposed regulations. On motion, duly seconded, it was agreed that this letter be sent with copies going to our Congressional Delegation, Governor Bond and the AMA.—**Referred to Reference Committee on Resolutions.**

■ In correspondence from the AMA, it was recommended that state medical associations study the possible present inadequacy of official medicolegal investigation of deaths. A motion was made, seconded and duly passed to refer this to the Commission on Medical-Legal Affairs.—**Referred to Reference Committee on Constitution and Bylaws.**

■ Mr. McIntyre said he had received correspondence from the AMA regarding state associations' views on Intern and Resident membership in the AMA—whether this should be through the Intern and Resident Business Section or through a county and state society. A motion was made, seconded and carried that Interns and Residents be accepted for membership to the AMA through the regular channels, i.e., through component societies.—**Referred to Reference Committee on Reports of Officers.**

■ Congressman James Symington is chairing House Health Subcommittee hearings on national health insurance on February 1 in St. Louis and on February 2 in Kansas City. Dr. Richard Bradley, President of the St. Louis Medical Society, is appearing on behalf of medicine and will speak at the hearing in St. Louis. Dr. Bradley has received input from the Washington Office of the AMA in regard to this hearing.

Mr. Mortenson stated that the AMA will analyze the differences between the Medicredit Bill, the Administration bill and the Kennedy bill, and he will try to get this information to the Council. He further stated that the hearings in St. Louis and Kansas City are strictly overview hearings and there would be no discussions of any specific piece of legislation.—**Referred to Reference Committee on Resolutions.**

■ Correspondence from the AMA indicates that the Council on Constitution and Bylaws of the AMA has the responsibility of studying a proposal for national medical specialty societies' direct representation in the AMA House of Delegates. They are seeking information from the different states regarding their views on this subject. Since time is of the essence, a motion was made, seconded and carried to provide that the President and Staff get together background information and answer the questions posed in the AMA inquiry. It was pointed out that the individual Councilors can send their comments to the AMA regarding this matter since the AMA is seeking opinions from a broad spectrum of membership. It was suggested that this might be published in the

Journal.—**Referred to Reference Committee on Constitution and Bylaws.**

■ A progress report from the Ad Hoc Committee on Midwifery was distributed to the Council. The Committee is not ready to make any recommendations at this time regarding legislation, but will continue its study and make a report to the Council at a future date.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ The Leadership Training Seminar will be held on Feb. 23-24, 1974, at the Ramada Inn in Jefferson City. Mr. Swarens asked the Councilors to give him the name of another physician in their respective districts to be invited to the Leadership Conference. Dr. Cope indicated that he had attended the Leadership Conference in Chicago and it was extremely well done. It was suggested that if some of the invited participants do not respond, a follow-up telephone call be made to them.

Mr. McIntyre stated that the membership brochure describing the services and benefits of MSMA membership, as prepared by Mr. Swarens, had received many favorable comments. The AMA has sent this brochure to all its Regional Field Directors suggesting that this might be something other states would like to do for their membership.—**Referred to Reference Committee on Reports of Officers.**

REPORTS OF DISTRICT COUNCILORS

■ *District #1*—Dr. Martin discussed matters pertaining to the Health Care Foundation in his area.—**Referred to Reference Committee on Resolutions.**

■ *District #3*—Dr. Franklin reported that the St. Louis Medical Society held a meeting of its delegation in regard to submitting resolutions on time. He said he was pleased at the reaction of most of the delegates to the proposed increase in dues. His delegates agreed with the manner in which elections to MSMA have been performed in the past.

District #2—Dr. Bach said that he had no formal report to present.

District #4—Dr. Hetlage stated that he has some very good and able county society officers in his district.—**Referred to Reference Committee on Reports of Officers.**

■ He said that some discussion has been held with Blue Shield regarding a multicarrier, closed-panel, HMO-type program and more will be heard about this.

The Blue Shield open panel program has had only a 33% response from physicians and, possibly, is stymied at least for the present time, since they have indicated they should have 80% response.—**Referred to Reference Committee on Resolutions.**

■ Dr. Hetlage reported that there has been discussion regarding a more equitable man-to-man representation in the House of Delegates and on the Council.—**Referred to Reference Committee on Constitution and Bylaws.**

■ Dr. Hetlage indicated that the Osteopathic Journal has published several articles regarding the foundation concept and reconstruction of organized medicine which he feels are good articles.—**Referred to Reference Committee on Resolutions.**

He said that the physician population in both St. Charles and Lincoln counties is growing rapidly.

■ *District #6*—Dr. Bradshaw reported that they have embarked on a regional concept of home health delivery system and have made application.

There is a proposal under study for an organization called a Rural Health Institute. This is a cooperative effort of the University of Missouri, Division of Health and others. More will be reported on this as it is developed to a better degree.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ *District #8*—Dr. McAlhany reported that Dr. Walter German was recently installed as President of the Greene County Medical Society.—**Referred to Reference Committee on Reports of Officers.**

■ Dr. McAlhany indicated that several surgeons in his area, who have never had a malpractice suit against them, were very unhappy about the tremendous increase in malpractice insurance premiums. He suggested that contact should be made with the Insurance Department regarding this.

It was moved that an ad hoc committee from the Council be formed to meet with the Superintendent of the Division of Insurance and these problems should be taken to him. The motion was seconded and carried.—**Referred to Reference Committee on Constitution and Bylaws.**

■ Dr. McAlhany stated that he had received a letter from General American seeking fee schedules so they could evaluate fees for certain services for 1970 and 1972.—**Referred to Reference Committee on Resolutions.**

■ Dr. McAlhany reported that the hospitals in Springfield, Joplin, Neosho and Branson have advised St. Louis Blue Cross that they would not renew their present contracts which expire in the near future. If these hospitals are not able to negotiate a new contract with Blue Cross, they will function as nonmember hospitals.—**Referred to Reference Committee on Resolutions.**

■ *District #9*—Dr. Cooper indicated that South Central Missouri Medical Society recently held a meeting and primarily followed the agenda of the Council.

Mid-Missouri Medical Society will hold a meeting next week with Representative Richard Ichord as the speaker.

District #10—Dr. Hansbrough reported that the Cape Girardeau County Medical Society has offered him one page each month in its monthly Journal and he is very pleased with this.—**Referred to Reference Committee on Reports of Officers.**

■ *District #5*—Dr. Bregant said that his district is still involved in the concept and structuring of a Health Care Foundation.—**Referred to Reference Committee on Resolutions.**

REPORT OF THE PRESIDENT

■ Dr. Stricker said that he hopes a number of Missouri physicians will be present for the AMPAC Workshop to be held in Washington, D. C., March 15-17.

Dr. Stricker reported that he had attended the St. Louis Medical Society installation of officers. Dr. Richard Bradley was installed as President. Dr. Stricker stated that the Mid-Missouri County Medical Society will have a meeting soon and Representative Richard Ichord will be the speaker. Representative Ichord will discuss national health insurance.—**Referred to Reference Committee on Reports of Officers.**

■ He discussed a letter which has been received from the President of the Association of American Physicians and Surgeons, Inc. inviting the MSMA and any local societies to join them in challenging the constitutionality of the PSRO law. The AAPS has filed suit in this regard in an effort to abolish the law.

A motion was made to request a copy of the legal brief from the AAPS, if this is deemed advisable by Legal Counsel. The motion was seconded and carried.—**Referred to Reference Committee on Resolutions.**

MISSOURI INSTITUTE OF PSYCHIARTY

■ Dr. Robert Felix, a member of the Mental Health Commission, gave the Council an informational report on activities, programs and problems of the Missouri Institute of Psychiatry since its inception in 1962 to the present time.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORT OF THE COMMITTEE ON VOLUNTARY HEALTH AGENCIES

■ Dr. William C. Allen, Chairman of the Committee on Voluntary Health Agencies, reported that his committee met on December 16. Invitations were extended to some 18 voluntary health agencies and 11 were in attendance. The meeting provided a forum in which each agency could explain its program to the physicians of Missouri and, also, have the opportunity to discuss mutual interests with the other agencies present. The purposes, needs and aims of each of the organizations were brought before the Committee. Along with presenting the purpose, size, type of membership and current activities of the voluntary health agencies, each representative was requested to express his opinion as to how the MSMA might best assist that agency. This segment led to the following recommendations by the voluntary health agencies represented:

(1) Physician involvement in voluntary health organizations both as members and to provide expert medical advice and guidance is essential.

(2) Physicians need to be better informed on services the agencies offer and, as a result, give their patients the opportunity to benefit from the services by referring the patient to the proper agency.

(3) Physician support for an agency's community service program greatly enhances the prospect for success of the program.

(4) Better liaison between physicians and voluntary health organizations should be a prime goal.

(5) That benefit should be gained from a similar meeting on an annual basis.

The Committee on Voluntary Health Agencies of the MSMA, therefore, makes the following recommendations:

(1) Physician members of the Voluntary Health Organizations should be encouraged to submit appropriate articles to Missouri Medicine for consideration for publication. The articles could include what the voluntary health agency offers to aid a physician's patient.

(2) The assignment of an MSMA staff member to be a contact point for voluntary health organizations with the MSMA office.

(3) The MSMA should give favorable consideration to the publication of a "Directory of Voluntary Health Organizations" similar in format to the AMA publication on National Voluntary Health Agencies to be distributed to the membership for their use. This publication would be updated annually.

Discussion followed regarding the manner in which this "directory" might be published.

On motion, duly seconded, the Council accepted the report of the Committee on Voluntary Health Agencies. The motion carried.

A motion was made, seconded and approved that the "directory" as suggested in Recommendation #3 be published in the roster edition of Missouri Medicine.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORTS OF THE DEANS

■ Dr. Allen indicated that since neither Dr. White nor Dr. Mayer could be present at the Council Meeting, he was asked to give a short report for the University of Missouri School of Medicine.

The Family Practice Program at the University is going well. There are now eight residents in family practice; six more will come in in July and another six the following year.

Discussions are now in progress in regard to the fact that at some point in the near future, they will have a set-up in a community near Columbia where Resident Physicians will have an opportunity to practice. If this program is successful, hopefully, one or two Residents will locate in that community and we can move on to another area. It is somewhat limited in scope away from Columbia, primarily due to the energy crisis.

Dr. Hetlage stated that there is a move to establish an emergency clinic in Warrenton and he understood this is to be staffed by University of Missouri resident physicians and will be under the auspices of the Boonslick Comprehensive Health Planning Agency.

Dr. Allen indicated that he was not aware of this program.

Dr. Bradshaw said that he felt that the University of Missouri might be considering priorities for these residency programs without contacting various areas in rural Missouri. He stated that, in some way, he would like to see the priority system of the communities to be served and be spread out so that it will not be concentrated in the University area.

Dr. Allen said that the program in the community near Columbia is a first step. If successful, it is hoped that other communities will be considered.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Dr. Bradshaw brought up the matter of lay education and use of Cassette tapes and the possible availability of documented programs on various health measures.

It was pointed out that there is a project coming into RMP that, if funded, should be of some help in this regard. This involves the combining of many of the programs that have been done and putting them into the proper form.

Mr. Schnedler said that a firm named TEL-MED and located in San Bernardino, Calif. has tapes covering numerous subjects. His understanding is that these tapes can be purchased or rented.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ Dr. Felix gave statistics on the large number of applicants St. Louis University has had in the last two or three years for the places in their freshman class. He also presented statistics on the number of applicants accepted, minority group representation in the classes and other statistics in regard to the recruitment of students. Dr. Felix reported that there were three members of the 1972 senior class interested in family practice and eight members in the 1973 senior class. In the 1974 class of 152, there are 26 members interested in family practice.

Dr. Felix stated that St. Louis University's students came from several different states and from various schools throughout the country. He reported that the last group of students who took Part 1 of the National Boards had done very well.—**Referred to Reference Committee on Medical Education and Public Welfare.**

EMERGENCY MEDICAL SERVICES PLAN FOR MISSOURI

■ Dr. Klippel said that Representative Roy of Kansas is planning to introduce a bill into Congress to pay for a student's medical education and he then would have to practice in a rural or ghetto area.

Dr. Klippel said that Senate Bill 57 was passed during the last session of the General Assembly. It provided certain standards for ambulance and ambulance personnel. This law does not go into effect until July 1, 1974. He said that there are several bills introduced in this session of the General Assembly calling for repeal of this law. Senate Bill 57 requires certain standards under which ambulances must operate: 44 hours of first aid training under the Red Cross for personnel and two persons to a vehicle.

Dr. Klippel stated that a bill has been introduced that will require the driver of a vehicle to wear his seat belt. He said that training programs for ambulance personnel are being devised throughout the state so that people who wish to get this training will have easy access to it. Dr. Klippel said that the purpose of the seat belt law is to keep the driver in his seat and in control of the car.

A question regarding categorization of hospitals was asked. Dr. Klippel stated that in areas in which there is only one hospital, there is no problem. He stated that in an area in which there are three or four hospitals, you get into trouble. The public assumes that if a hospital is rated third or fourth for emergency services, it is a third- or fourth-rate hospital. It would be good to get away from numbers altogether. Hospitals are categorized by services that are available.—**Referred to Reference Committee on Miscellaneous Affairs.**

AMA REPORT

■ Mr. Mortenson stated in December of 1973 that the AMA House of Delegates had expressed the opinion that repeal of the PSRO law is in the best interest of the public. He indicated that each state Council or Board had been sent a letter asking them if they will work for repeal.

Mr. Mortenson stated that the AMA Board of Trustees intends to file a lawsuit against the Department of Health, Education and Welfare if it did not change proposed regulations for preadmission certification. The HEW has requested a meeting with the Board on February 6.

Mr. Mortenson reported that the AMA Board is reconsidering legal action on Phase 4, Mandatory Wage and Price Controls on Physicians. He indicated that it is going to be a rough legislative year. He also mentioned President Nixon's health insurance proposal and the Kennedy proposal.

Mr. Mortenson reported that there is a bill in Congress that calls for dissolving CHP and for creating local units which could be problematic.—**Referred to Reference Committee on Resolutions.**

■ The St. Louis City Medical Society survey report is to be presented to them on February 14. In regard to the AMA membership incentive reimbursement of $55, Mr. Mortenson stated that the AMA had to have notification by February 8 if a county society wishes to participate in this program. —**Referred to Reference Committee on Reports of Officers.**

■ Mr. Mortenson stated that in regard to malpractice insurance programs offered by Associations, it is illegal for a company to insist that you get other insurance from them in order to get malpractice insurance with them.—**Referred to Reference Committee on Constitution and Bylaws.**

■ HEW had sent out a letter stating that copies of Medicare prevailing charges were available for inspection in carrier offices and regional HEW offices. Mr. Mortenson stated that there is no charge for inspection or for copies of ten pages or less, but there will be a charge of 25¢ per page for any other pages copied plus mailing costs.—**Referred to Reference Committee on Resolutions.**

■ Mr. Mortenson reported that Missouri had a 102% growth in AMA membership last year, but indicated that only 46.1% of doctors in Missouri are dues-paying members of the AMA.—**Referred to Reference Committee on Reports of Officers.**

■ Dr. Hetlage asked Mr. Mortenson how many states are on record as favoring nonparticipation in PSRO. Mr. Mortenson stated that at present, there are five or six states which had taken this position. Mr. Mortenson stated that this is an active legislative year and everyone should use every vehicle he can use to get into Washington.—**Referred to Reference Committee on Resolutions.**

REPORT OF THE COMMISSION ON MEDICAL ECONOMICS, THIRD PARTY MEDICINE AND GOVERNMENTAL RELATIONS

■ Dr. Peterson, Chairman of the Commission, made the following recommendations to the Council:

1. The Commission recognizes the gross inequities of third party fee payments in Missouri. The Commission feels that a physician should handle any payment that he believes to be inequitable through proper channels initially with the help of local medical societies and the state medical association.

2. It is recommended that an analysis and summary of pertinent national health insurance bills be published in Missouri Medicine at an early date.

3. It is recommended that the major health insurance carriers be contacted to obtain their contract coverage code concerning contract benefits. If these contract codes were available to individual physicians it would greatly assist public relations and service among physicians, patients and carriers.

4. It is recommended that the problems between physicians and the Aetna Insurance Company be pursued further.

5. It is recommended that an MSMA survey be made concerning the delay of payments by carriers. The survey should be statistically oriented to cover solo practitioners, groups and the various specialties. Information should be obtained concerning the seven or eight larger carriers. It should ask for the number of days from the date the claim was filed until the payment was received by the physician.

6. It appears that there seems to be a growing practice for insurance companies, their agents, employees, investigative organizations and other third parties in connection with obtaining medical data to simply photograph physicians' patient medical records. This practice is obviously a convenient method to obtain information but, simultaneously, it permits access to substantially greater amounts of information than is necessary or is intended through the release authorized by the patient. The AMA Council on Medical Service has an ongoing program to examine and explore possible solutions to the various problems inherent in this subject. They feel strongly that the preservation of the confidentiality of medical information developed during the course of the physician-patient relationship is an ethical obligation of the medical profession.

7. It is recommended that physicians be encouraged to participate and become active and informed in comprehensive health planning programs. They should fully recognize the importance of CHP as a force in the health system—now and in the years to come.

8. The next item discussed by the Commission was renal dialysis and transplants under Medicare and the AMA House of Delegates policy to oppose retainer type fees. The Chairman will appoint an ad hoc committee to study this subject and to make recommendations to the Council at a later date.

9. Dr. Heeb's report of the Advisory Committee to the Missouri Division of Welfare was accepted with commendation. It is recommended that the following resolution be submitted to the MSMA House of Delegates:

Whereas, Some physicians have been dropping out of the Medicaid Program because of inconsistent payments of services, unrealistic denial of coverage of many services, and retroactive denial of payments, and

Whereas, Many of the services retroactively denied are overhead items to the physician making it possible for him to actually lose money in the program, and

Whereas, The dentists have a definite fee schedule, and

Whereas, The Welfare recipient in the State of Missouri is finding it increasingly more difficult to find adequate medical care, therefore be it

Resolved, That the Missouri State Medical Association approve the negotiation of a definite fee schedule and list of ancillary services provided for Title XIX recipients, and be it further

Resolved, That the negotiated fee schedule be renegotiated on an annual basis.

It is understood that this will need to be done under the framework of present laws concerning antitrust and restraint of trade.

10. After considerable discussion of the preadmission approval procedures for elective hospital admissions that were published in the Jan. 9, 1974 *Federal Register,* it is recommended that the MSMA make known their opposition to the *Federal Register* notice requiring prehospital admission certification and that a letter of such opposition be sent to the Social Security Administration Washington Office and that, additionally, we recommend the Council contact members of the Missouri Congressional delegation and inform them of our opposition.

11. PSRO was the next item discussed by the Commission. Dr. Peterson explained the AMA actions at the 1973 Clinical Session of the House of Delegates. The Commission discussed Report EE adopted by the AMA House of Delegates.

The Commission agreed wholeheartedly with the recent MSMA Council action on PSRO and recommended that it be supported. This position is "That the Council believes that the PSRO law should be repealed or effectively amended and work actively with the Missouri Congressional delegation to this end."

12. Cost of Living Council and Physician Fees under Phase IV. The Commission recommends that a resolution be drafted and presented to the MSMA House of Delegates concerning the actions of the Cost of Living Council and Physician fees and will draft this resolution in time for it to be placed in the Delegates Handbook.

13. Blue Shield. Dr. Chastain discussed background of the open panel plan proposed by St. Louis Blue Shield. He stated that as of the meeting date, participation agreement had been received from only 30% of the physicians and that the St. Louis Blue Shield Board of Directors felt that they needed 80% participation before this plan could be offered. This plan has been approved by MSMA.

Dr. Hetlage stated that this Commission is saddled with an almost overwhelming amount of responsibility and, perhaps, consideration should be given to establishing a subcommittee or ad hoc committee to handle the governmental relations portion of the Commission work.

Dr. Hetlage moved that a governmental relations subcommittee under the auspices of the Commission be appointed with sufficient staff help to allow them to stay abreast of rapidly changing government programs. This Committee is to be appointed by the Chairman. The motion was seconded by Dr. Martin and adopted.

A motion to accept this report was made by Dr. McAlhany. The motion was seconded and carried.—**Referred to Reference Committee on Resolutions.**

UNI-MED SERVICES, INC.

■ Mr. Herbert Strohson, Executive Vice-President of Uni-Med Services, outlined the background of the formation of Uni-Med, which is a consulting firm which provides assistance to groups who wish to form Health Care Foundations. He presented in detail the services offered by Uni-Med.

Mr. Strohson presented background information on the formation of the Southeast Missouri Health Care Foundation and said that his company is in the process of helping a Mid-Missouri group form a health care foundation in that area. He reported that Uni-Med had recently become associated with the Health Care Foundation of Missouri in the capacity of consultants.

Dr. Hetlage asked how much control Uni-Med maintains over a foundation after it has been set up and is in operation. Mr. Strohson stated that, originally, Uni-Med contracted for a period of five years. Uni-Med takes a certain percentage of the money brought in through services generated by them. But at any time during the five-year period, the doctors in the Foundation can buy out Uni-Med. After the original five-year contract, contracts are negotiable on a yearly basis and a particular foundation can renew or not renew Uni-Med's contract as it sees fit. Mr. Strohson stated that through contracts with insurance carriers, it is hoped that benefits could be raised and through peer review costs could be lowered.—**Referred to Reference Committee on Resolutions.**

ACUPUNCTURE

■ Dr. Marcy Goldstein stated that he had been asked to present a report on acupuncture. Dr. Goldstein stated that sometime ago, he had attended a five-day seminar on acupuncture and had become extremely interested in it. He attended an acupuncture course in England, passed the British examination and now does some acupuncture. He said that the traditional Chinese concept of acupuncture is that all things alive have an energy flow and there are channels through which the energy is thought to flow. The Chinese feel that the energy flows continuously throughout the body and you see affects where you are treating, but it also affects the next acupuncture meridian and so on throughout the body.

Dr. Goldstein stated that four states (Massachusetts, Oregon, Maryland and the District of Columbia) have passed laws relating to acupuncture. If acupuncture is recognized as a healing art, then there has to be some way of regulating and controlling it. If acupuncture is done improperly or by an untrained person, complications can occur. Dr. Goldstein stated that at present, there is no way to qualify persons practicing acupuncture. He said that he would like to see a law in the state that calls for (1) licensing of acupuncturists and (2) a patient who wishes to see an acupuncturist would have to have a letter from a physician referring him to the acupuncturist.

Dr. Goldstein stated that he did not treat all diseases with acupuncture. Dr. Hetlage stated that he felt an acupuncturist should have some knowledge of medical conditions. Dr. Hansbrough stated that he felt that if this is going to become a legal problem, criteria for training has to be set up. Dr. Goldstein stated that he felt that criteria needs to be developed in regard to training required for licensing, but, at present, there is no school in the United States where there is a training program. Dr. Cope indicated that the legislative thrust should be restrictive rather than permissive. Dr. Hetlage stated that you cannot consider an enabling law without establishing criteria for training. Dr. Hansbrough pointed out that NIH now has a program to study acupuncture. Perhaps, we should wait and see what type of criteria they come up with.—**Referred to Reference Committee on Miscellaneous Affairs.**

REMARKS OF THE DIRECTOR OF DIVISION OF HEALTH

■ Dr. Domke stated that the nursing home industry is growing in Missouri. In 1962, there were only 42 licensed professional homes in the entire state. In 1971, there were 122. Although growth of licensed homes, both professional and practical, has been rapid, there is still a problem with unlicensed homes. A recent Missouri law states that a boarding home cannot have patients who require nursing home care, and under the law, the Division of Health is to check out these homes and license them. To date, the Division of Health has licensed some 60 boarding homes and has applications from about 300 others.

Dr. Hetlage stated that there are many people who could not afford nursing homes and asked where they would go if they had to be moved from the boarding homes. Dr. Domke stated that if people indicated that they could not afford nursing homes, there are various state programs which could take over the fiscal responsibility for these people.—**Referred to Reference Committee on Resolutions.**

■ Dr. Domke stated that the Board of Health had been requested to develop recommendations for a family planning program for the state. The Board has reviewed some plans, including the report of the MSMA Family Planning Committee. Dr. Domke stated that he would like to have an adhoc committee from MSMA to assist him in developing a plan for the state.

Dr. Bradshaw moved that an ad hoc committee of the Council be appointed to consider family planning in consultation with the State Board of Health and the Division of Health. The motion was seconded and carried.

The Chairman appointed the following members to this committee: Dr. Hetlage, Chairman; Drs. Martin and Bregant.

Dr. Domke stated that an immunization manual is being printed and will be available shortly. Dr. Domke stated that the Division of Health had contracts funded for 50 ambulances under the new ambulance law passed during the last Session of the Legislature.—**Referred to Reference Committee on Miscellaneous Affairs.**

REPORT OF THE WOMAN'S AUXILIARY

■ Mrs. Willman reported that the Auxiliary held an excellent environmental health symposium last fall and an impressive fall conference.

The Auxiliary will again hold its annual meeting in conjunction with the MSMA Annual Meeting. The Auxiliary is streamlining its meeting this year. All its business will be conducted in one day. On Saturday, the Auxiliary will have a workshop to better inform members of their programs. On Saturday, a 50th Anniversary Luncheon will be held. There also will be a party honoring all past-presidents of the Auxiliary. Mrs. Willman offered the Auxiliary's assistance on any matter for which the MSMA would like to have help.

Dr. Chandler stated that the Auxiliary had indicated to him that it would require an additional $400 to help finance its annual meeting. The Auxiliary has been given $600 in previous years.

The motion was made to appropriate $1,000 to the Auxiliary to assist in financing its annual meeting. The motion was seconded and carried.

REMARKS OF THE SPEAKER OF HOUSE OF DELEGATES

Dr. Slickman stated that he hoped the House of Delegates could assign the major portion of its work at the first session of the House, but they will only be able to do this if resolutions are in the handbook. Dr. Slickman asked the Councilors for suggestions for members of Reference Committees. Dr. Slickman reported that if there were a standing vote on any matter he felt that the count would be more accurate if each Councilor District appoints a Delegate from that district, seated in the House, to count the votes of the Delegates in that Councilor District and report them.—**Referred to Reference Committee on Reports of Officers.**

PRACTICE MANAGEMENT WORKSHOP

■ It was indicated that the MSMA should move ahead on the Practice Management Workshop for May.

A motion was made by Dr. Martin that the Council go ahead on this workshop. The motion was seconded and carried.—**Referred to Reference Committee on Reports of Officers.**

PROPOSAL FOR MSMA-SPONSORED MALPRACTICE INSURANCE PROGRAM

■ Dr. McAlhany stated that Mr. Kenneth Lincoln, an attorney from Phoenix, Ariz., had prepared a proposal for an MSMA-sponsored Medical Malpractice Insurance Program. There was a large fiscal note on this proposal and it was felt by the Council that funds are not available at the present time to implement Mr. Lincoln's plan. It was suggested that a letter be sent to Mr. Lincoln declining his offer and thanking him for his efforts.

Dr. Paul R. Young of Columbia *(left)*, Chairman of the MSMA Ad Hoc Committee on Continuing Medical Education, and Dr. George H. Ladyman of Poplar Bluff, Chairman of the Commission on Continuing Education and Health Manpower.

A motion was made by Dr. McAlhany to write to Mr. Lincoln declining his offer and thanking him for his efforts. The motion was seconded and carried.—**Referred to Reference Committee on Constitution and Bylaws.**

LEGAL COUNSEL

■ Mr. McIntyre stated that inasmuch as Mr. Noble is no longer retained on a regular basis as the MSMA legal counsel, approval by the Council was needed to obtain the services of a law firm in Jefferson City when needed for MSMA business. A motion was made to authorize the obtaining of such legal services. The motion was seconded and carried.

Dr. Hetlage stated that he felt a gift or some measure of appreciation should be made to Mr. Noble for his many years of service to the Association.

Dr. Hetlage moved that a suitable award for service be presented to Mr. Noble during the Presidents' dinner at the annual meeting. The motion was seconded by Dr. Gunn and carried.—**Referred to Reference Committee on Reports of Officers.**

DUES

■ Mr. McIntyre stated that at the last Council, the report of the Planning Committee was accepted. It included a recommendation for a Dues increase because of the need of additional services and personnel. He stated that a proposal to implement this had been drawn up in regard to the proposed dues increase with the suggestion that it be included in the Handbook. The Council is responsible for the financial recommendations for the operation of the Association. The following recommendation for the dues increase proposal to be in the Delegates' Handbook was presented and discussed:

The Charter of the Missouri State Medical Association reads:

> "The purposes of the Missouri State Medical Association are to bring into compact organization the entire medical profession of the State of Missouri with the view of the extension of medical knowledge and the advancement of medical science, to promote and elevate the standards of medical education and the enactment and en-

forcement of just medical and public health laws, to encourage friendly intercourse among physicians, to guard and sustain measures of interest and advantage to the public and medical profession and to promote science, knowledge and skill among the medical profession—all with the objective of improving the public health."

These purposes demonstrate the vital role of the Association. And, it is the responsibility of the MSMA to upgrade and expand its services and benefits to carry out these stated purposes.

In an effort to upgrade and expand its service and benefits to the membership, the Council of the MSMA has endorsed several recommendations of the Committee on Long Range Planning and the Commission on Continuing Education and Health Manpower. These recommendations include:

1. Additional staff to improve communications between the MSMA and its members and between the medical profession and the public;
2. Creation of a contingency fund for each Councilor whereby each Councilor can directly disseminate information and establish better communications within his District;
3. Creation of a "Policy Manual" consisting of actions taken by this House of Delegates and the Council on major issues and dissemination of this Manual to all MSMA members for easy reference regarding the Association's official policy;
4. Implementation of additional member benefits such as developing our own professional liability insurance company group, automobile leasing program, term life insurance, group cash reserve insurance, group automobile insurance, membership retirement plan and other benefits desired by the membership;
5. Initiation of a viable continuing medical education program to be carried out by the MSMA for its members;
6. Continuation of the $10 assessment on MSMA members for funding of the Missouri State Medical Foundation's student loan program for another three-year period with an increase in interest rates to encourage repayment of loans.

Obviously, the implementation of the above recommendations will result in additional costs. In addition, due to inflation factors faced by all individuals and organizations, merely maintaining current activities of the MSMA is becoming more costly.

If the MSMA is to remain a viable organization which will meet its obligations to its membership, we must face the fact that more money is needed.

A proposal for a dues increase is seldom greeted with enthusiasm and, be assured, the Council of the MSMA carefully studied all facets of this proposal before it was approved.

Perhaps there is little comfort in comparison of dues structures that exhibit just how low MSMA dues actually are at this time. But it is interesting to note on the attached sheet that the MSMA currently has the second-lowest dues structure in the nation. That would be fine if the dues provided enough funds to carry out the activities required of an active Association—but they don't! Another point of comparison is that dues for full membership in the Missouri Association of Osteopathic Physicians and Surgeons is $150 annually plus a donation of $100 for osteopathic colleges. Also, dues in the Missouri State Chiropractic Association are $100 annually.

The recommended budget of the MSMA for 1974, without taking into consideration the recommendations of the Committee on Long Range Planning, shows that expenditures will exceed income by $5,248. Implementation of any new services will push the deficit even higher.

In light of the current monetary situation detailed above and taking into consideration the recommendations for expanded services for Association members, the MSMA Council recommends an increase of $25 in dues for members of this Association. This would raise the dues structure from the current $65 per year to $90 per year. Combined with the $10 annual assessment for funding of the Missouri State Medical Foundation's student loan program, the total billing to members would be $100 annually effective Jan. 1, 1975.

Therefore, the Council of the Missouri State Medical Association offers the following Resolution:

Resolved, That Chapter VIII, Section 1(a) of the 1973 Revised Bylaws of the Missouri State Medical Association be amended on line 2 by striking out the figures "$65" and inserting in lieu thereof, the figure "$90" and further amend Section 1(a) in line 3 by striking out the date "1970" and inserting in lieu thereof the date "1975," and be it further

Resolved, That Chapter VIII, Section 1(b) of the 1973 Revised Bylaws of the Missouri State Medical Association be amended on line 3 by striking out the date "1972" and inserting in lieu thereof the date "1975."

SUMMARY OF ANNUAL DUES OF ACTIVE MEMBERS OF STATE MEDICAL ASSOCIATIONS[*]

		50th Percentile	
Alaska	$450	Arizona	$120
Nevada	260	Oklahoma	120
Montana	200	New Hampshire	120
South Carolina	180	Oregon	115
Utah	165	Indiana	110
Colorado	150	Maryland	110
Idaho	150	Georgia	100
Iowa	150	Mississippi	100
District of Columbia	145	Nebraska	100
Wisconsin	145	New York	100
Delaware	140	Pennsylvania	100
Hawaii	140	Rhode Island	100
California	135	Vermont	100
75th Percentile		*25th Percentile*	
Michigan	$135	West Virginia	$100
New Mexico	135	North Carolina	95
Illinois	131	New Jersey	90
Kentucky	130	Louisiana	85
Alabama	125	Massachusetts	85
Arkansas	125	Tennessee	80
Kansas	125	Texas	80
Maine	125	Florida	75
Minnesota	125	Missouri	75
North Dakota	125	Puerto Rico	73
South Dakota	125	Connecticut	70
Wyoming	125	Ohio	65
Washington	122	Virginia	60

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[*] For 1974. Includes District of Columbia and Puerto Rico.

The motion was made to approve the above recommendation. The motion was seconded and unanimously carried.—**Referred to Reference Committee on Reports of Officers.**

MENTAL RETARDATION

■ Dr. Chandler stated that the Council had discussed the Governor's mental retardation proposal and it was their feeling that we should favor this.

A motion was made to accept the mental retardation proposal in principle. The motion was seconded and carried.—**Referred to Reference Committee on Miscellaneous Affairs.**

REPORT OF COMMITTEE ON LEGISLATIVE AFFAIRS

■ Dr. Matthews gave the following Legislative Report:

Senate Bill 336 (Physical Therapist Regulations) has PASSED the Senate. This bill strengthens the present law by prohibiting a person not licensed as a physical therapist from representing himself as a physical therapist.

Senate Bill 341 (Delegation Amendment) and *House Bill 1328* (Sick Doctor Statute) have been reported DO PASS and *House Bill 1487* (Insurance for Newborn) will be reported DO PASS Monday.

The *Delegation Amendment* places into statutes that a physician's assistant, R.N. or L.P.N. can provide certain medical assistance to patients if such assistance is rendered under the direct and personal supervision, control and responsibility of a licensed physician. An attempt by the optometrists to amend this bill was headed off in the committee, but a floor fight is expected.

The *Sick Doctor* bill appears to be sailing along and is on the PERFECTION CALENDAR in the House awaiting a floor vote.

Proponents for the *Insurance for Newborn* bill were heard last Monday and opponents, if any, will be heard next Monday. However, it appears certain the bill will be reported DO PASS.

Hearings have been held on the *Ambulance Law Repeal* bills, *Prescription's Safety Caps* bill, *Abortion Limitation* bill, *Medical Students Grants* and elimination of insurance *Coordination of Benefits* bill, but none have been reported out by the committees. The Ambulance bills are being studied by a subcommittee.

House Bill 972 (Acupuncture) was heard last week and, at the suggestion of the MSMA, the bill was referred to a subcommittee for further study. As written, the bill sets up minimum requirements for licensure as an acupuncturist and does *not* consider acupuncture as the practice of medicine. The committee is sympathetic with us on these points, but feels that some type of regulations should be set down to prohibit unqualified persons from practicing acupuncture. We have furnished the subcommittee additional information for study.

A motion was made, seconded and adopted to approve this portion of the report.

Two bills supported by this Council have not been heard by Committees to date, largely because the Senate has been tied up with Reorganization matters.

These are *Senate Bill 561* which would license and regulate commercial clinical laboratories operating in Missouri but would *not* affect a private physician's laboratory; and *Senate Bill 520* which provides that health insurance policies must offer minimum benefits for mental or nervous conditions.

In the UNFAVORABLE BILL column, *House Bill 1334*, the perennial bill which would remove the words "by hand" from the chiropractic law, and *House Bill 971* which would reduce the requirements for physical therapists have not been heard. It is possible the latter bill may be withdrawn.

Bills which have surfaced since our last meeting and on which you may wish to take a position include:

House Bill 1401 (Drugs—Generic Name) which would require physicians to include the generic name with the brand name on all prescriptions. Pharmacies would be required to post a list of brand name drugs with the generic equivalents and a price list.

No position was taken on House Bill 1401.

House Bill 1254 is the Governor's mental retardation bill. We have received a favorable reaction to the bill from the OB-GYN section and have received a request from the Governor for support. The bill will be heard by Committee at 8:00 p.m., Monday.

Action has been taken previously on House Bill 1254.

House Bill 907 (Psychologist Regulation) establishes a committee to test, license and regulate psychologists. One group of state psychiatrists have expressed approval of the bill.

House Bill 1400 (Health, Education Facilities) would establish a state authority with the power to issue notes and bonds to finance construction of health and education facilities. Authority could either lend money to approved institution for building or finance the construction and then lease.

House Bills 907 and 1400 have been presented for information only.

House Bill 1654 (Legislative Health Affairs Committee) would establish permanent Joint Legislative Committee on Health Affairs to study health care resources, services and systems in state and make recommendations to the General Assembly for action to improve and coordinate health services, facilities and educational opportunities. Bill will be heard by Committee next Wednesday.

House Bill 1514 (Rural Health Care Commission) would create a Commission on rural health care to be appointed equally by the House, Senate and Governor to make continuing study of rural health care needs including shortage of physicians and other health care personnel and facilities.

No position was taken on House Bill 1654 and House Bill 1514.

House Bill 1263 (Alcoholism—Treatment) states that alcoholics or intoxicated persons are *not* to be criminally prosecuted for consumption of alcohol, and creates a Bureau in the Division of Mental Health to establish and maintain treatment programs.

House Bill 1264 (Alcoholism—Insurance) is a companion bill to HB 1263 and would require group accident and health insurance policies to provide benefits for treatment of alcoholism in licensed hospitals.

The Legislative Committee recommends approval of these two bills in principle.

House Bill 1596 (Lab Personnel Licensing) provides for licensing and regulation of clinical lab personnel under the Division of Health.

No position was taken on this bill.

Senate Bill 546 (Corporate Income Tax) adds a 40% surcharge to corporation's income taxes, with the money earmarked for local governments. This replaces local funds lost by repeal of personal property and intangible tax.

Senate Bill 546 has been presented for information only.

State Reorganization Measures are still before the Legislature and the status of the bills change almost hourly as it bounces back and forth between the House-Senate Conference Committee and the Administration. The MSMA is attempting to preserve and retain present statutory powers of the Board of Health, Cancer Commission and the Board of Registration for the Healing Arts.

It was agreed to support reorganization measures and a seat belt law.

Dr. Hetlage moved that the Council go on record as favoring a strong law requiring the driver of a moving automobile to have his seat belt securely fastened. The motion was seconded and carried.

A motion was made, seconded and carried to approve this portion of the report.

Dr. Hetlage stated that Dr. C. Read Boles had contacted him and suggested that at Legislative committee hearings, members of various specialties would like to testify on bills that pertain to a certain specialty. Perhaps county executives could be notified when hearings will be held and they, in turn, could contact doctors who would testify.

Dr. Matthews stated that anyone could contact his local library and get a WATS line number to call for full information on any bill in the Legislature.

Dr. Cope moved acceptance of the entire report with commendation. The motion was seconded and adopted.—**Referred to Reference Committee on Miscellaneous Affairs.**

■ Dr. Bradshaw asked why Councilor expenses for the Annual Session were not paid. Mr. McIntyre stated that there is a provision in the Bylaws stating that Councilors' expenses for the Annual Session will not be paid.

Dr. Hetlage stated that Mr. Fox had been unable to schedule the December, 1974 Council Meeting at the Ramada Inn in Jefferson City. He suggested that, perhaps, we could go to the Lodge of the Four Seasons or to some place other than Jefferson City.

A motion was made to have the December, 1974 Council Meeting at the Lodge of the Four Seasons, if possible. The motion was seconded and carried.

NEXT COUNCIL MEETING

Dr. Chandler stated that the Council meeting before the Annual Session will be held at 3:00 PM on Wednesday, April 3 at the Crown Center Hotel in Kansas City.—**Referred to Reference Committee on Reports of Officers.**

Supplementary Council Report

Dr. Chandler then presented a supplementary report on the Council Meeting held on Wednesday, April 3, 1974 in the Crown Center Hotel in Kansas City. He reported as follows:

"The MSMA Council met in the Mission Room of the Crown Center Hotel on Wednesday, April 3, 1974 with Dr. R. Allen Chandler presiding.

"The minutes of the Feb. 1, 1974 Council Meeting were approved as published.

"Mr. McIntyre indicated that Mr. Tom P. Fox, Executive Assistant in the MSMA Headquarters Office, retired as of April 1. However, he will be with us during this Annual Session. He then introduced Mr. Ron Ellison, who will assume Mr. Fox's duties.

(The Speaker referred this portion of the report to the Reference Committee on Reports of Officers.)

"The Health Care Foundation law suit hearing was held on March 4 before the St. Louis Court of Appeals. We will now await a decision from the Court. However, we do not know when this will be handed down.

(The Speaker referred this portion of the report to the Reference Committee on Resolutions.)

"Mr. Cooper reported that the seven-day Greek Tour, previously approved by the Council, is no longer feasible costwise and asked the Council's approval to join the Florida Medical Association on a two-week Greek Tour in August, 1974. It was moved, seconded and carried that such approval be granted.

"Dr. Hubert Ritter presented a first-place plaque received from AMPAC for Missouri's outstanding contributions to the PAC movement.

(The Speaker referred this portion of the report to the Reference Committee on Reports of Officers.)

"Mr. McIntyre reported that the Governor's Advisory Council for Comprehensive Health Planning will hold a Health Manpower Conference on April 22-23 in Jefferson City and has asked for our participation. This Conference is set up to develop a mechanism for a planning system for health manpower in the state of Missouri. Comprehensive Health Planning has been informed that we will participate in this Conference and encourage physician attendance.

(The Speaker referred this portion of the report to the Reference Committee on Medical Education and Public Welfare.)

"President Stricker gave a brief report on the various meetings he has attended in recent weeks.

"Dr. Stricker presented the following resolution regarding Mr. Tom Fox:

Whereas, Thomas P. Fox retired effective April 1, 1974 from his position as Executive Assistant of the Missouri State Medical Association and Assistant Secretary of the Missouri State Medical Foundation; and

Whereas, Tom has earned the respect and friendship of the many members and others with whom he has come into contact by his sincere and energetic service to the Association and Foundation for the past 13 years; and

Whereas, His effectiveness and competence has helped guide the Association and Foundation to positions of high standing among physicians and the public; and

Whereas, His wisdom, friendliness and personal character will be sorely missed by all those persons who come into contact with the MSMA Staff; be it therefore

Resolved, By the House of Delegates of the Missouri State Medical Association sitting at its 116th Annual Session in Kansas City, Missouri, that Tom be formally commended and accorded the highest praise for devoted service to the doctors of Missouri; and be it further

Resolved, That the House express to Tom on behalf of the entire membership the esteem and affection in which he is held by the doctors of the state; and be it further

Resolved, That the House extend to him the good wishes of the profession for health and happiness in the years to come.

"It was moved, seconded and carried that this resolution be approved and presented to the House on Thursday, April 4.

(The Speaker referred this portion of the report to the Reference Committee on Reports of Officers.)

"Mr. Cooper reported that a recent meeting of the Commission on Medical-Legal Affairs was held in cooperation with the Missouri Bar Association and the Missouri Association of Osteopathic Physicians and Surgeons. The Commission again recommends that the Council provide funds in the amount of approximately $30,000 to develop a group professional liability insurance program for MSMA members. A previous proposal to develop this insurance program was not approved by the Council due to budgetary limitations.

"It was moved to accept the report on Medical-Legal Affairs deleting any specific amount of money that would be expended to underwrite such a program. The motion was seconded and carried with one dissenting vote.

(The Speaker referred this portion of the report to the Reference Committee on Constitution and Bylaws.)

"Mr. Swarens gave a brief report on the activities of the MSMA Committee on Midwifery. This Committee set forth the steps they felt necessary in the initiation of a Nurse-Midwifery Program in Missouri. The Committee recommends that this be referred to the Legislative Committee for drafting of proposed legislation.

"It was moved, seconded and carried that this be referred to the Legislative Committee for their perusal, recommendations and report back to the Council.

(The Speaker referred this portion of the report to the Reference Committee on Miscellaneous Affairs.)

"Dr. Joseph V. Finnegan, Editor of Missouri Medicine, recommended the reappointment of the present members of the Editorial Board and the Publications Committee. It was moved, seconded and carried that the present members be reappointed.

"Dr. Finnegan indicated that the Publications Committee will hold a meeting on Saturday to discuss some of the financial difficulties that the Journal is facing due to loss of advertising.

(The Speaker referred this portion of the report to the Reference Committee on Reports of Officers.)

"Dr. McAlhany reported on the meeting held with the Superintendent of the Division of Insurance regarding the malpractice insurance situation in Missouri. The Superintendent furnished information regarding malpractice insurance premiums through 1971 and will forward 1972 figures as soon as they are available. Dr. McAlhany suggested that when these are received that they be turned over to an insurance actuary to assist in analyzing the situation. After that time, the Insurance Superintendent will call a public hearing if so desired. It was felt that this was a very fruitful meeting.

(The Speaker referred this portion of the report to the Reference Committee on Constitution and Bylaws.)

"Dr. Hetlage presented a preliminary report on the Ad Hoc Committee on Family Planning. There are currently 22 family planning clinics operating in the state of Missouri, including five separate activities in the St. Louis area. They are operating independently of one another under separate grants from the federal government with the only coordination being that rendered by representatives of a number of social agencies loosely formed and called The Family Planning Council.

"Analysis of responses would seem to indicate a lack of coordination of activities, a great latitude in the scope of operation of some individual clinics and a wide variation in costs per patient visit.

"The Division of Health has been contacted by the Department of HEW relative to the development of a grant application to HEW for the statewide operation of these clinics. Dr. Herbert Domke is to develop a plan to establish a supervisory function for the State Health Department with a new advisory board with a large physician representation. In the meantime, the Ad Hoc Committee is to remain as an advisory committee to the State Board of Health in this matter.

"It is understood that additional grants from HEW for the operation of clinics currently in operation will not be granted during a moratorium of approximately six months to allow the State Health Division to organize for functioning in this capacity. The state is to operate, or to supervise, one grant operating in Springfield and possibly an additional grant to the Kansas City area.

"The Ad Hoc Committee on Family Planning recommends the following:

"1. MSMA support the Division of Health in its desire to coordinate the activities of the family planning clinics.

"2. Increase local medical society participation in the supervision of these clinics.

"3. Continued input by MSMA in the operation and supervision of these clinics by the Division of Health.

"4. For geographic representation on the proposed advisory council.

"5. That the Ad Hoc Committee be retained as a subcommittee of the Council to act in an advisory capacity to the Division of Health and to keep the Council informed of the program.

"It was moved, seconded and carried to accept this preliminary report of the Ad Hoc Committee on Family Planning.

(The Speaker referred this portion of the report to the Reference Committee on Miscellaneous Affairs.)

"Dr. Bonebrake, Chairman of the Insurance Advisory Study Committee, recommended the following new insurance programs to the Council for their approval:

"1. Term life; 2. Overhead; 3. Major Medical.

"It was moved, duly seconded and the Council accepted the report of the Insurance Advisory Study Committee with commendation.

(The Speaker referred this portion of the report of the Reference Committee on Reports of Officers.)

"Dr. Matthews presented an up-to-date legislative report. This report was accepted by the Council.

(The Speaker referred this portion of the report to the Reference Committee on Miscellaneous Affairs.)

"Dr. Hubert A. Ritter, St. Louis Medical Society, indicated that he would submit a resolution at the upcoming session of the House of Delegates regarding Unified Membership with the American Medical Association.

"Dr. Hansbrough requested that the Council recommend to the House of Delegates that Carter County in the Ninth Councilor District, which has no practicing physicians, be transferred to the Tenth Councilor District inasmuch as the medical services for this county are primarily provided by physicians in the Tenth Councilor District.

(The Speaker referred this portion of the report to the Reference Committee on Constitution and Bylaws.)

"Brief reports were presented by Dr. William Mayer, Dean, University of Missouri School of Medicine-Columbia, and Dr. Noback, Dean, University of Missouri School of Medicine-Kansas City.

(The Speaker referred this portion of the report to the Reference Committee on Medical Education and Public Welfare.)

"Dr. Martin reported that Dr. Donald Dowell, Chillicothe, Past-President of MSMA, is seriously ill in St. Luke's Hospital. It was agreed by the Council that a card of Best Wishes for his recovery be sent.

(The Speaker referred this portion of the report to the Reference Committee on Reports of Officers.)

"Mr. Mortenson, AMA Field Representative, reported on various national health insurance proposals, namely, a bill termed the Kennedy-Mills national health insurance proposal and a bill known as the Rogers-Roy Bill, which, if in effect, would establish state health commissions similar to that of public utilities to control the practice of medicine. A resolution opposing this particular bill will appear in this Session. He indicated that these bills undoubtedly will cause much concern and work on the part of physicians all over this country in seeing that this legislation is modified as best as possible for the welfare of the people of this country.

"Mr. Mortenson reported that Dr. James Sammons has been appointed to succeed Dr. Ernest Howard as Executive Vice-President of AMA upon Dr. Howard's retirement. Dr. Richard Palmer has been elected Chairman of the Board of Trustees and Dr. John Chenault as Vice-Chairman of the Board. Dr. Chenault is our guest from the AMA at this Convention. We're very happy to have him.

(The Speaker referred this portion of the report to the Reference Committee on Miscellaneous Affairs.)

"Mr. Speaker, this concludes the supplementary report of the Council."

(The supplementary report of the Council was accepted.)

NOMINATING COMMITTEE

Dr. Stricker named the following members to the Committee on Nominations: Drs. Frank B. Matteson, C. C.

Cohrs, Richard V. Bradley, Frederick D. Peterson, Robert Hall, James A. Reid (Chairman), George J. Lytton, William M. Walker, Jack Bass and George H. Ladyman.

Unfinished Business

The Speaker invited consideration of unfinished business.

The Speaker then asked the Delegates to consider two amendments to the Constitution and Bylaws which have been held over from the 115th Annual Session of the MSMA in 1973.

(The Speaker referred to the Report of the Committee on Constitution and Bylaws (see page 326) in which the Committee recommends that the two amendments accepted by the House during the 1973 session be adopted.)

The recommendation of the Committee on Constitution and Bylaws reads as follows:

"The Committee recommends that Article IV of the Constitution be amended by inserting a comma following the word "Association" and adding the following words: 'the Speaker and Vice-Speaker.'

The amended sentence in Article IV of the Constitution would then read as follows:

> The House of Delegates shall be the legislative body of this Association and shall consist of Delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker, who will serve as Delegates-at-large.

The amendment to the Bylaws would be identical.

(It was moved and seconded that both amendments be adopted. The motion was approved by a two-thirds vote.)

The second Constitutional amendment recommended by the Committee on Constitution and Bylaws and adopted by the House of Delegates at the 1973 Annual Session is a substitute for Article IX and reads as follows:

> Petitions signed by 10% of the active members of the Association, including petitioners representing at least one half of the component Medical Societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

(It was moved and seconded that the amendment be adopted. The motion was carried by a two-thirds vote.)

Introduction of New Business

The Speaker invited the introduction of new business.

The Speaker noted that since Resolutions #1 through #39 had been submitted in time for inclusion in the Delegates Handbook, their introduction from the floor was as not required. The resolutions are as follows:

Resolution #1—Rotation of MSMA Presidency

(Introduced by St. Louis County Medical Society)

Whereas, Only three (3) members of Saint Louis County Medical Society and Fourth Councilor District have been president of Missouri State Medical Association in the last 52 years; and

Whereas, The rotation of the presidency between Kansas City, Saint Louis and Northern and Southern Missouri has systematically excluded our societies; and

Whereas, This has been brought to the attention of the Officers and Council of Missouri State Medical Association and no remedial action accomplished or proposed; now, therefore be it

Resolved, That the bylaws of Missouri State Medical Association specify that the rotation for presidency of the Missouri State Medical Association include the Fourth Councilor District every fifth year.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #2—Seat Belt Legislation

(Introduced by St. Louis County Medical Society)

Whereas, Annually almost 60,000 people die on the highways in the United States including Missouri; and

Whereas, There is well-documented evidence from Australia that the use of seat belts, enforced by law, has reduced this toll by 18%; and

Whereas, Many people, especially the young, do not realize the importance of the use of seat belts; and

Whereas, A mandatory seat belt law will allow this state to receive additional Federal Highway Funds of 10, 15 or 25% more than now allotted; now, therefore be it

Resolved, That:

1. The House of Delegates of MSMA goes on record in favor of a seat belt law being passed by the General Assembly of the State of Missouri, and,
2. A copy of this Resolution be sent to all of the members of the General Assembly to encourage them to pass such legislation and, thereby, make more money available to this state for highway development as well as help to protect the citizens of Missouri from injury or death.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #3—Hospital Medical Staff Autonomy

(Introduced by Clay County Medical Association)

Whereas, Duly licensed and credentialed doctors of medicine and osteopathy, have primary responsibility in diagnosing and treating patients in the hospital setting; and

Whereas, The American College of Hospital Administrators and the American Hospital Association have been busy since 1970 in attempts to bring about changes in the constitution and bylaws of the medical staffs at their hospitals, the point of these revisions being to increase the authority and control of hospital administrations over private physicians and hospital staffs, and to interject hospital administration into daily medical decision making of medical doctors in the hospital setting; and

Whereas, The best medical care will accrue to the in-hospital patient in a setting where there is a twofold division of authority—one in which the administration runs the physical plant and supportive services of the hospital, and one in which the medical staff is responsible for the medical practice in the hospital; and

Whereas, It is imperative that each medical staff maintains its sovereignty in relationship to its organization structure, credentialing and peer review of its members and in overseeing the quality of care practiced by its members; be it now therefore

Resolved, That the House of Delegates of the Missouri State Medical Association upholds the principle of hospital medical staff autonomy, and the principle which states that the control of medical practice must remain in the sole hands of the medical staff, uncoerced and unrestricted by hospital administration; and be it further

Resolved, That the MSMA House of Delegates makes each physician member aware, by all available educational means, that certain forces in the hospital field are attempting to bring about this increased authority of hospital administrations to control private physicians on hospital staffs; and be it finally

Resolved, That each member physician of the MSMA be urged to be certain that no bylaws changes are allowed to be effected in the hospitals where he practices which would tend to dilute his authority to use his best medical judgment in the care of his patient.

(Referred to Reference Committee on Medical Education and Public Welfare.)

Resolution #4—Physician Nonparticipation in PSRO Activities

(Introduced by Clay County Medical Association)

Whereas, The PSRO law passed by Congress as HR-1 in 1973 implies that medical doctors are incompetent, outdated and unlearned; and

Whereas, This law further implies that medical doctors are dishonest and deceitful and disinterested in the welfare of their patients; and

Whereas, This law further implies that each of us as practicing physicians is guilty of misuse of federal funds in the caring for our patients until we are proven innocent; and

Whereas, The implementation of this law will create a sterile, noninnovative, ultra-conservative, computerized type of medical care for the citizens of the United States; and

Whereas, The law is punitive, providing for a fine of up to $5,000 per patient, if a reviewing committee finds that patients are unnecessarily admitted to hospitals; and

Whereas, The review of all medical work relating to Medicare and Medicaid patients will be under the total and final control of the Secretary of HEW under the existing PSRO law; and

Whereas, Doctors' experiences in the realm of utilization review in connection with Medicare and Medicaid to date has been fraught with frustrations of retroactive denials by a paid employee of the fiscal intermediary for the Social Security Administration; and

Whereas, There is no certain assurance in the existing PSRO law that the opinion of reviewing doctors will be final, and not subject to reversal by the Secretary of HEW; and

Whereas, The reason for PSRO is primarily economic and not educational, as was advertised by the author of the law; and

Whereas, The prospects of any medical educational value of the PSRO law would seem as unlikely as that pertaining to the present Medicare-Medicaid utilization review; and

Whereas, There has been a tremendous ground swell from the rank and file members of the American Medical Association as evidenced by the December Anaheim AMA meeting urging the AMA to support in every way that it can, the abolition of this yoke-like law; and

Whereas, No physician can be forced into participating in PSRO review; and

Whereas, Implementation of the PSRO law without doctors to do the reviewing would be chaotic and would allow the law to fall into disarray and sink out of sight, be it now therefore

Resolved, That the House of Delegates of the Missouri State Medical Association goes on record as urging each of its member doctors to refrain from participating in any PSRO review; and be it further

Resolved, That the House of Delegates recommends to each individual member of the MSMA that he continue his in-hospital review activities, so that adequate and effective peer review might be accomplished; and be it finally

Resolved, That the Missouri Congressional Delegation be appraised of the position of the Missouri State Medical Association on this vital and important issue by providing each legislator with a copy of this resolution, and by urging each lawmaker to work vigorously for abolition of this law.

(Referred to Reference Committee on Resolutions.)

Resolution #5—MSMA Parliamentary Procedure

(Introduced by Jackson County Medical Society)

Whereas, The work of the House of Delegates of the Missouri State Medical Association should be as uncomplicated, expeditious and efficient as possible; and

Whereas, Newer systems of parliamentary procedure appear to lend themselves to these goals more readily than do older, traditional systems; and

Whereas, The American Medical Association is among the many organizations which have discarded the classic Robert's Rules of Order in favor of more contemporary systems of parliamentary procedure; now, therefore, be it

Resolved, That the Bylaws of the Missouri State Medical Association be amended in such a manner as to assure that the deliberations of the House of Delegates, its Councils, Committees and other subsidiary units be conducted in accord with the most recent edition of Sturgis Standard Code of Parliamentary Procedure.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #6—MSMA Specialty Representation

(Introduced by Jackson County Medical Society)

Whereas, The medical profession in recent years has become somewhat fragmented by the growth and increasing activities of medical specialty organizations; and

Whereas, There now appears to be a demonstrable need for the profession to strive for unity of purpose and coordination of action in order to respond to the many economic, political and sociological pressures which are being brought to bear upon it; and

Whereas, A considerable degree of unity and coordination might be attained by bringing specialty organizations back together in what has been described as the "main stream" of organized medicine; now, therefore, be it

Resolved, That the Constitution and Bylaws of the Missouri State Medical Association be amended in such a manner as to provide for representation of medical specialties in the House of Delegates of the Association; and be it further

Resolved, That said representation shall be limited to two Delegates for any medical specialty which can demonstrate to the satisfaction of the House that it is organized on a statewide basis, that it has continuing organizational activities, that it has as least 50 active members and that at least nine-tenths of said members are members of the Missouri State Medical Association.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #7—MSMA Council Chairman

(Introduced by Jackson County Medical Society)

Whereas, The activities of the Council of the Missouri State Medical Association have increased substantially in recent years; and

Whereas, This increased activity has added substantially to the duties and concerns of the Chairman of the Council; and

Whereas, The Chairman of the Council should be free to concentrate his attention upon the needs of the State Association without concern for activities and problems of his own Councilor District; now, therefore, be it

Resolved, That the Constitution and Bylaws of the Missouri State Medical Association be amended in such a manner as to free the Chairman of the Association's Council from any official ties with or responsibilities to the Councilor District which elected him and to enable him to concentrate all of his thoughts and energies on the duties and responsibilities of the Chair; and be it further

Resolved, That the Constitution and Bylaws of the Missouri State Medical Association be further amended to provide that when a member of the Council is elected to the position of Chairman, the District Council seat which he occupied shall be declared vacant and the District shall be entitled to select a new Councilor.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #8—Discriminatory Fees

(Introduced by Mineral Area Medical Society)

Whereas, The geographical location where a physician practices does not necessarily reflect either his competence or a reasonable fee schedule, and,

Whereas, Physicians should be encouraged to locate in areas of greater need, and,

Whereas, Subscribers to insurance policies do not receive lower rates because they live in an area where prevailing physician fees are low, therefore, be it

Resolved, That the Missouri State Medical Association requests the State Insurance Commissioner to prohibit discrimination on the basis of geographical location in the determination of reasonable fees for reimbursement by third party payers.

(Referred to Reference Committee on Resolutions.)

Resolution #9—Professional Standards Review Organizations

(Introduced by Mineral Area Medical Society)

Whereas, The PSRO regulations will interpose a needless and deleterious third party into the physician-patient relationship; and

Whereas, The PSRO regulations will destroy the confidentiality essential for patient confidence and rapport with his physicians; and

Whereas, The implementation of PSRO standards will eventually produce a rigid structure of approved recipes for diagnosis and treatment of illnesses, preventing individualization and innovation in patient care; and

Whereas, The American health care system is the best in the world and would be detrimentally affected by PSRO; therefore be it

Resolved, That the Missouri State Medical Association hereby opposes the implementation of PSRO and requests the Missouri Congressional Delegation to seek the immediate repeal or appropriate amendment of this law, so that the health care of Missourians will not be adversely affected.

(Referred to Reference Committee on Resolutions.)

Resolution #10—MSMA-Sponsored Group Professional Liability Insurance Program

(Introduced by Greene County Medical Society)

Whereas, Since 1968, professional liability insurance premiums have been increasing astronomically; and

Whereas, Professional liability carriers are refusing to renew contracts or to issue new contracts to several physicians that are members of the Association; and

Whereas, Approximately 34 State Medical Associations now sponsor group professional liability programs for the benefit of their members, offering as a most important feature the availability of professional liability insurance to all members of the Association; and

Whereas, Another outstanding feature of a group program is the establishment of responsible physician committees to analyze, review and advise the carrier concerning any claims brought before it; and

Whereas, There is centralized claims handling, complete financial disclosure as to rates, claims and reserves, and active defense of all non-meritorious claims; therefore be it

Resolved, That it appears that a group professional liability insurance program would be of great benefit to the members; and be it further

Resolved, That the House of Delegates authorizes the Council of MSMA to implement a group professional liability insurance program with dispatch.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #11—Solicitation by Medical Laboratories

(Introduced by Greene County Medical Society)

Whereas, Medical Laboratories located outside the state of Missouri have been soliciting mail-order urinalysis of Missouri residents; and

Whereas, Mail-order urinalysis can create a false sense of security in individuals who are ill but are normal so far as their urine is concerned; and

Whereas, We believe that a urinalysis and other laboratory tests should be done by the patient's own physician, who would, in addition to making such analysis, be able to make other physical findings to enable him to advise his patient properly and to give him a complete picture of his physical condition; therefore be it

Resolved, That the Legislative Committee of the Missouri State Medical Association be instructed to prepare proper legislation to prohibit this type of mail-order medical practice in Missouri; and be it further

Resolved, That this legislation be introduced in the Missouri General Assembly as soon as it is feasible.

(Referred to Reference Committee on Medical Education and Public Welfare.)

Resolution #12—Opposition to PSRO

(Introduced by Greene County Medical Society)

Whereas, Public Law 92-603 has established Professional Standards Review Organizations, which we believe will have harmful effects on the quality, confidentiality and cost of medical care; and

Whereas, PL 92-603 (PSRO) offers nothing to prohibit interference in the manner in which we practice medicine and, in fact, gives broad powers of control to the Secretary of HEW; and

Whereas, The Missouri State Medical Association through the Health Care Foundation of Missouri has already established a mechanism for providing peer review in the State of Missouri; and

Whereas, The American Medical Association House of Delegates, at the 27th Clinical Convention in Anaheim, December 1-5, 1973, approved a PSRO policy pointing out that the best interests of the American People would be served by repeal of the legislation; therefore be it

Resolved, That the Missouri State Medical Association supports the AMA policy on PSRO adopted at the AMA 27th Clinical Convention; and be it further

Resolved, That the MSMA Council be instructed to inform the public and the members of the Senate and House of Representatives from Missouri of the "potential deleterious effects of this law on the quality, confidentiality, and cost of medical care"; and be it further

Resolved, That the MSMA works with and through the local county medical societies and hospital staffs to continue to develop effective peer review programs; and be it further

Resolved, That the MSMA takes all legal steps to resist the intrusion of any third party into the practice of medicine; and be it further

Resolved, That the MSMA works diligently to seek repeal of the PSRO provision of PL 92-603; and be it further

Resolved, That the MSMA encourages its members to take the position of "non-implementation" of PSRO; and be it further

Resolved, That copies of this resolution be filed with the members of the Senate and House of Representatives from Missouri, as well as the Secretary of HEW.

(Referred to Reference Committee on Resolutions.)

Resolution #13—Hospital Governing Board and Medical Staff Relationship

(Introduced by Greene County Medical Society)

Whereas, During the past few years, the number of disputes between hospital governing boards and organized medical staffs has been increasing at an alarming rate, and

Whereas, The basic issue in these disputes is whether the hospital or the physician is primarily responsible for the care and treatment of patients, and

Whereas, There has been a developing trend on the part of some hospital governing boards to attempt to exercise direction and supervision over staff physicians due to an erroneous interpretation of the Darling case *(See Appendix)*, therefore be it

Resoved, That the House of Delegates of the Missouri State Medical Association directs their officers and Council to provide for each one of the members the pertinent information as to the real implications of the Darling Decision, and be it further

Resolved, That the Missouri State Medical Association through proper channels encourages the physicians not to make any immediate changes in the constitution and bylaws governing the activity of the hospital staff, and be it further

Resolved, That this information reminds the doctors of their responsibility to the patients even though they be in a facility not under the control of the physician.

APPENDIX to RESOLUTION #13—Hospital Governing Board and Medical Staff Relationships
THE DARLING CASE

Some hospital administrators, governing boards and their attorneys who cite the Darling case as a precedent would have physicians believe that the hospital is jointly responsible for any act of malpractice they may commit in the delivery of medical services within the hospital. With this as a base, they say that if the hospital is responsible for the attending physician's mistakes, it has the right to supervise and direct his medical services. This is not what the Darling case holds.

The true significance of the Darling case, though hardly mentioned by legal commentators, is simply this: when a hospital selects for a patient the physician who is to treat him, it has an obligation to act wisely in selection. Commentators seem to overlook the fact that although Darling, the injured football player, was taken to the emergency room of the Charleston Community Memorial Hospital, he was not taken there for emergency treatment. He had received emergency treatment from the school physician at the time the injury occurred on the football field. When the nurse on duty telephoned a general practitioner to come and set the broken leg, the hospital, in effect, provided a physician incompetent to perform the required tasks. There was no immediate risk of death or loss of limb which compelled the physicians on call to treat the injury rather than calling an orthopaedic surgeon from the hospital's consulting staff.

Despite the language in the Darling case as to the failure of the hospital to abide by its own bylaws relating to the required consultation or to fulfill the applicable Standards of the Joint Commission on Accreditation of Hospitals and the hospital licensure regulations of the State of Illinois, none of these considerations would have been discussed in the case if the physician involved had been selected by Darling to be his attending physician rather than selected by the hospital to provide treatment.

The nub of the Darling case is simply that although the doctor was not an employee having a contract of service with the hospital, his hospital privileges required him to have in effect a "contract for services" in the hospital by being available for treatment on emergency call. Therefore, although he may not have been a servant of the hospital, a common law principal and agent relationship could be implied and is apparent in the decision.

When a hospital governing board uses attending physicians to man its emergency room it must provide adequate services and if the hospital interprets emergency services as something beyond merely preventing the loss of life or limb or the alleviation of severe pain, it can anticipate legal liability for the malpractice of its medical staff members. But there has not been one single reported case in which a hospital has been held legally responsible for the malpractice of an attending, competent physician engaged in independent practice and selected by the patient.

(Referred to Reference Committee on Medical Education and Public Welfare.)

Resolution #14—Involvement of Third Parties in the Practice of Medicine

(Introduced by Greene County Medical Society)

Whereas, Third parties including the federal government through Medicare and Medicaid and their intermediaries, insurance companies and hospitals continue to make capricious rulings as to procedures and/or fees; and

Whereas, This makes an orderly practice of medicine impossible; and

Whereas, It is contemplated that there will be even more third party involvement; therefore be it

Resolved, That all persons or organizations be informed that decisions involving physician care must be discussed with the involved physicians or their representatives before such changes are made.

(Referred to Reference Committee on Resolutions.)

Resolution #15—Discrimination Regulations of the Cost of Living Council

(Introduced by Greene County Medical Society)

Whereas, Cost of Living Council Regulations are discriminatory for the physicians in these United States; and

Whereas, Regulations which have been issued are unfair even if not discriminatory; and

Whereas, These regulations are unnecessary because of the restraint which physicians have used in the increase of fees over the past several years making our impact on the national economy negligible; therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association directs its officers and Council to take all feasible steps to bring about the discontinuance of these regulations; and, be it further

Resolved, That this House of Delegates requests the AMA, its officers and Board of Trustees to double their efforts on the behalf of their members in bringing about the discontinuance of these regulations.

(Referred to Reference Committee on Resolutions.)

Resolution #16—Improved Communications With MSMA Membership

(Introduced by Greene County Medical Society)

Whereas, One of the continuing problems of Missouri State Medical Association is direct contact with its members; and

Whereas, The lack of money for employment of personnel and not the diligence of these already employed is the cause of this lack of contact; therefore be it

Resolved, That the House of Delegates supports the dues increase; and be it further

Resolved, That additional field men be employed to work with the physicians of Missouri in carrying out the business of the organization.

(Referred to Reference Committee on Reports of Officers.)

Resolution #17—Use of Combination of Drugs

(Introduced by Greene County Medical Society)

Whereas, The Food and Drug Administration continues to discourage the use of combination of drugs; and

Whereas, 40% of drugs are used in combinations according to their own survey; and

Whereas, The same drugs are still used in combination but at double prices because the drugs are supplied separately; and

Whereas, This results in further overall increase in costs; therefore be it

Resolved, That the physicians of Missouri, the Missouri State Medical Association and the American Medical Association continue its efforts to encourage the Food and Drug Administration to study carefully the prescribing habits of physicians before discontinuing a combination of drugs packaged together.

(Referred to Reference Committee on Medical Education and Public Welfare.)

Resolution #18—National Health Insurance

(Introduced by Greene County Medical Society)

Whereas, The President of the United States, as well as many others, is now supporting a national health insurance plan; and

Whereas, The recent history of the federal government has produced plans which are designed (and poorly) mainly for cost containment rather than good medical care; and

Whereas, The present system of medical care has resulted in better care for more people than any other in the history of the world; therefore be it

Resolved, That any system of national health insurance be designed with the consultation and aid of the practicing physicians from the very beginning; and be it further

Resolved, That the welfare of the patient be the guiding principle for this plan; and be it further

Resolved, That all steps be taken to provide a mechanism so that the patient knows the value of the services he receives to the point of real participation in the payment for services; and be it further

Resolved, That no promises or hopes be held forth which are obviously impossible.

(Referred to Reference Committee on Resolutions.)

Resolution #19—Pre-Admission Certification

(Introduced by Greene County Medical Society)

Whereas, The Department of Health, Education and Welfare in regulations published January 9, 1974, promulgated among other rules that of pre-admission certification; and

Whereas, It is the physician's sole responsibility to make the diagnosis and prescribe the treatment; and

Whereas, Pre-certification abrogates the physician's ability to prescribe the treatment by inserting another mechanism in this process involving personnel who have neither the training or responsibility in the process; and

Whereas, This will result in a lower level of medical care; and

Whereas, It will increase the overall cost of hospital care—the very item it is designed to curtail; and

Whereas, It is a punitive regulation against hospitals with no mechanism for appeal; therefore be it

Resolved, That the physicians of Missouri continue to oppose this regulation vigorously; and be it further

Resolved, That all steps be taken by the Officers and Council to see that this regulation is not implemented.

(Referred to the Reference Committee on Resolutions.)

Resolution #20—Physician Involvement in Comprehensive Health Planning

(Introduced by Greene County Medical Society)

Whereas, Comprehensive Health Planning is no longer a "Review and Consent" organization but a true regulatory arm of the federal government; and

Whereas, Its power seems destined to penetrate to every level of health care activities; and

Whereas, Physicians have expertise which is unique to them only; therefore be it

Resolved, That this House of Delegates of the Missouri State Medical Association urges all county societies to take an official interest in this activity by assigning a member to be an official part of the organization; and be it further

Resolved, That this representative make regular reports to his society and the Missouri State Medical Association on activities in his area.

(Referred to Reference Committee on Resolutions.)

Resolution #21—Cost of Living Council Regulations

(Introduced by Commission on Medical Economics, Third Party Medicine and Governmental Relations)

Whereas, Cost of Living Council Regulations are discriminatory for the physicians in these United States; and

Whereas, Regulations which have been issued are unfair even if not discriminatory; and

Whereas, These regulations are unnecessary because of the restraint which physicians have used in the increase of prices over the past several years making our impact on the national economy negligible; therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association directs its Officers and Council to take all feasible steps to bring about the discontinuance of these regulations; and be it further

Resolved, That this House of Delegates requests the AMA, its Officers and Board of Trustees to double their efforts on the behalf of their members in bringing about the discontinuance of these regulations.

(Referred to Reference Committee on Resolutions.)

Resolution #22—Malpractice Insurance

(Introduced by Butler-Wayne-Ripley County Medical Society)

Whereas, For the past several years, malpractice insurance premiums have been going up; and

Whereas, Malpractice insurance people drop present physicians and refuse to issue policies to some physicians; and

Whereas, A large number of other state medical associations sponsor malpractice programs for their members; therefore be it

Resolved, That perhaps an MSMA-sponsored malpractice program would be of benefit to the physicians of Missouri; and be it further

Resolved, That the House of Delegates requests that the Council attempt to develop a malpractice program for its members as soon as possible.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #23—Insurance Coverage for Mental Illness

(Introduced by Ralph L. Biddy, M.D.,
St. Louis Medical Society)

Whereas, There are many citizens who have health insurance coverage that either does not cover or does not adequately cover for mental or emotional illness, and

Whereas, Many insurance companies have found it wholly feasible and economical to provide basic minimum coverage for mental illness; and be it

Resolved, That the Missouri State Medical Association supports a minimum health insurance act such as Senate Bill 520 requiring minimum inpatient and outpatient mental health benefits in all health insurance policies issued in the State of Missouri.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #24—Drunk Drivers

(Introduced by Patrick C. Hogan, M.D.,
St. Louis Medical Society)

Whereas, Life is a singular gift, received but once, and

Whereas, Life is constantly threatened on the State's highways by intoxicated drivers, be it

Resolved, That the Missouri State Medical Association urges and cooperates with the Legislature in an advertising and any other programs to remedy the situation, and that the House of Legislature and Governor be so notified.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #25—Reasonable Life Sustenance

(Introduced by Patrick C. Hogan, M.D.,
St. Louis Medical Society)

Whereas, The Medical Profession has always dedicated itself to the preservation of life and the alleviation of suffering, be it

Resolved, That the Missouri State Medical Association is of the opinion that no one should be deprived of "REASONABLE" means of life sustenance regardless of maturity, age, sex, color, creed, psychic state or financial status.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #26—Life Begins at Conception

(Introduced by Charles A. Jost, M.D.)

Whereas, The time when an egg cell and a sperm cell unite to form a new cell with a unique heredity is called the moment of conception, and

Whereas, Many authorities in the sciences of biology, physiology, anatomy and embryology agree that life begins at the moment of conception, therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association accepts the scientific evidence that life begins at the moment of conception and instructs the Secretary to so inform the Supreme Court of the United States.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #27—Definition of Life and Death

(Introduced by Patrick C. Hogan, M.D.)

Whereas, A definition of life, its beginning and its end is necessary to aid in the formulation and interpretation of laws, therefore be it

Resolved, That a Committee of University Professors of Neurology, Medicine, Obstetrics, Pediatrics and Surgery be commissioned to research and report the definitions to the House of Delegates of the AMA.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #28—Legislation to Teach Human Physiology in Secondary Schools

(Introduced by Paul L. Friedman, M.D.,
St. Louis Medical Society)

Whereas, Many diseases result from a person's mishandling of his own body by activities such as smoking, overeating and indulgence in alcohol and other drugs, and

Whereas, Many diseases are more successfully treated if early signs are recognized and medical care is sought at the onset, and

Whereas, There is presently no formal method to teach the lay public the facts of proper care of their body or what the signs of disease are, and

Whereas, The school systems have historically taken the responsibility for education, therefore be it

Resolved, That this House of Delegates of the Missouri State Medical Association calls upon the Legislature to pass all necessary legislation to create factual, academically-founded courses in the school system to teach human physiology and pathophysiology at the elementary and secondary level, and be it further

Resolved, That the legislature sets standards so that these courses are taught by teachers with the proper biological education, and be it further

Resolved, That copies of this resolution be sent to Governor Bond and to each of the state legislators.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #29—Apply PL 92-603 (Sect. 249F) to Government Hospitals in Missouri

(Introduced by Richard V. Bradley, M.D.,
St. Louis Medical Society)

Whereas, Section 249F, PL 92-603 was approved by the Senate, House of Representatives, and signed into law on September 30, 1972 as a cost containment measure for medical services rendered to persons under Social Security, and

Whereas, Section 249F, PL 92-603 contains the implication that unnecessary medical services may be provided to persons under Social Security, and

Whereas, Section 249F, PL 92-603 ascribes to the Secretary of Health, Education and Welfare unilateral authority to the survey of privileged communication between patients and their physician if the patient comes under Social Security, and

Whereas, Section 249F, PL 92-603 contains no contract responsibility on the part of the patient in contrast to minutely detailed contract responsibility for health care providers, and

Whereas, Conduct of Affairs stated in Section 249F, PL 92-603 would compromise the quality of medical care in favor of reducing the cost of medical care, and

Whereas, Application of the intent of Section 249F, PL 92-603 would cause physicians, hospitals and supporting specialties of the Private Sector to work out the errors and trials of this program, and

Whereas, The time required to experiment with the implementation of Section 249F, PL 92-603 would need to be subtracted from time spent in actual patient care, therefore be it

Resolved, That the patients, physicians, hospitals and extended care facilities based in the State of Missouri who provide or receive medical care under the auspices of Social Security and HEW delegate the Missouri State Medical Association to act in their behalf by:

1. Requesting of the Social Security Administration and the Department of HEW that Section 249F, PL 92-603 be applied in Government owned and controlled hospitals and extended care facilities now in operation in the State of Missouri for a period of two years.
2. Requesting the Social Security Administration and Department of HEW to report on this experiment publicly to the citizens of Missouri at the end of two years as to benefits derived and problems encountered.
3. Requesting that any implementations of Section 249F, PL 92-603 be deferred in non-governmental Missouri institutions pending above report.
4. Forwarding a copy of this action to the AMA.

(Referred to Reference Committee on Resolutions.)

Resolution #30—Ratify the Equal Rights Amendment

(Introduced by Paul L. Friedman, M.D.,
St. Louis Medical Society)

Whereas, Many citizens are denied equal rights before the law because of their sex; and

Whereas, Many of the same citizens suffer mental disease because of this denial of rights; and therefore be it

Resolved, That this House of Delegates of the Missouri State Medical Association calls upon the legislature to ratify the Equal Rights Amendment to the United States Constitution.

(Referred to the Reference Committee on Miscellaneous Affairs.)

Resolution #31—Complete Maternity Coverage

(Introduced by Hubert A. Ritter, M.D.,
St. Louis Medical Society)

Whereas, It is recognized that the nation's most valuable resource is its children; and

Whereas, Many insurers do not provide complete maternity care when maternity benefits are provided; and, therefore be it

Resoved, That every insurer issuing an individual, group or hospital service corporation policy of health insurance which provides maternity coverage, must provide complete maternity care. Complete maternity care is defined to include:

1. Normal obstetrical care
2. All complications of obstetrical care
3. Prenatal care
4. Care of unborn infants
5. Labor, delivery, and puerperium
6. Newborn care from the moment of birth

Complete maternity coverage should be included in all policies for those in the childbearing years whether married or single.

Deductibles and co-insurance may be allowed if proportional to the deductibles and co-insurance recorded for medical and surgical care coverage.

In order to provide continuity of coverage, the following eligibility period should be written into all insurance policies concerning benefits for obstetric care: "A pregnancy which begins while the insurance is in force should be covered until the termination of the puerperium and until the newborn infant is discharged from the hospital to home care"; and be it further

Resolved, That the Missouri State Medical Association lends its full support to have this resolution introduced in the Missouri State Legislature in proper form.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #32—Politics in VA Hospitals

(Introduced by Richard V. Bradley, M.D.,
St. Louis Medical Society)

Whereas, The Senate of the United States passed Public Law 92-603; and

Whereas, The House of Representatives of the United States passed Public Law 92-603; and

Whereas, Section 249F of Public Law 92-603 relieves the legislative branch of the government from any utilization review in public and private hospitals by placing said responsibility with the Department of HEW; and

Whereas, The Senate and House of Representatives have long been encumbered with frequent patient and Veterans' representative requests to intercede in matters pertaining to medical care in Veterans Hospitals; therefore be it

Resolved, That all requests by patients and Veterans' representatives rendered to Senators or Representatives or their staff, personnel, be sent direct to the department of HEW without benefit of a personal form letter answer from the legislator to the patient or his Veterans' representative.

(Referred to Reference Committee on Resolutions.)

Resolution #33—Coordination of AMA-ERF Fund Recipient With Practicing Physician

(Introduced by Charles S. Sherwin, M.D.,
St. Louis Medical Society)

Whereas, Many members of the American Medical Association and its local component societies and their auxiliaries have individually and collectively contributed funds for the purpose of student loans through the AMA-ERF, and

Whereas, Such loans have aided many worthy medical students some of whom might otherwise have had great difficulty in completing their medical school curriculum, and

Whereas, Many of these students and their colleagues may not be made fully aware of the ultimate source of such loans, that is the individuals who are members of such component societies and their wives as members of such auxiliaries, and

Whereas, Many physicians in the past have benefitted greatly as medical students from a close friendship with a physician who was actively caring for patients, therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association hereby recommends that student recipients of loans from the AMA-ERF be assigned to such a physician actively caring for patients, such physician to act as confidant, friend, advisor and, in general, as a representative of organized medicine, and be it further

Resolved, That such physician assigned shall be a faculty member in each student's respective school, a frequent contributor to the AMA-ERF and either currently or in the past, active in local component society affairs, and be it further

Resolved, That such assignment shall be made by the Delegate to the AMA from the State in which the school is located, and be it further

Resolved, That the physician so assigned shall agree to maintain the same degree of confidentiality in this relationship that he is accustomed to maintain in his relationships with his patients, and be it further

Resolved, That a copy of this Resolution be transmitted to the House of Delegates and the Board of Trustees of the American

Medical Association by the Delegates of this Association to the American Medical Association.

(Referred to Reference Committee on Reports of Officers.)

Resolution #34—AMA Membership for Medical School Faculty

(Introduced by Hubert A. Ritter, M.D.,
St. Louis Medical Society)

Whereas, $50,000,000 in loans have been made available to medical students through the AMA-ERF, and

Whereas, Much of this money is being utilized by students who are attending medical schools whose faculty make no effort to inform themselves of the benefits of the American Medical Association and whose actions and policies are not in concert with the ideals as enunciated by the AMA, and therefore be it

Resolved, That AMA-ERF uncommitted loans be made available only to medical students who attend schools where tenured physician faculty is composed of no less than 80% members of local and state medical societies, as well as the American Medical Association, and be it further

Resolved, That this resolution be forwarded to the AMA House of Delegates for further consideration and/or implementation.

(Referred to Reference Committee on Reports of Officers.)

Resolution #35—Support of House Bill 1254

(Introduced by Francis X. Lieb, M.D.,
St. Louis Medical Society)

Whereas, Mental Retardation is a health problem of significant proportions on a local as well as a national basis, and

Whereas, It has been well documented that significant improvement in the incidence of Mental Retardation can be obtained with good Pre-natal care and by prompt vigorous care of the Infant born at high risk, and

Whereas, At this time, many who need good Pre-natal care and intensive care of the high risk infant are unable to avail themselves of it either because of lack of facilities, lack of knowledge or for economic reasons, now therefore be it

Resolved, That the MSMA declares its support for House Bill 1254, Prevention of Mental Retardation, which provides for State support for the above mentioned facilities and programs, and be it further

Resolved, That the Missouri State Legislature be informed of the support of the MSMA.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #36—Repeal of PSRO Legislation

(Introduced by Charles A. Jost, M.D.,
St. Louis Medical Society)

Whereas, The House of Delegates of the AMA at Anaheim, California in December, 1973 affirmed the following principles:

"That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

"That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

"That the Association suggests that each hospital staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

"That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and the legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules will protect the public.

"The considered opinion of this House of Delegates is that the best interest of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our long standing policy and opposition to this legislation prior to passage."

Therefore Be It Resolved, That the 1974 House of Delegates of the MSMA declares its support of these principles and instructs the Council to so inform: The Missouri Legislature; The members of the United States Congress; The Secretary of HEW and the President of the United States.

(Referred to Reference Committee on Resolutions.)

Resolution #37—A. N. Vaughn Citation, 1890-1974

(Introduced by James M. Whittico, M.D.,
St. Louis Medical Society)

Whereas, The late Dr. Arthur N. Vaughn began his medical and surgical career in the City of St. Louis in 1917 and has steadfastly and without exception adhered to the highest principles of the art, science and ethics of the practice of medicine; and

Whereas, Dr. Vaughn was always a scholar, leader and gentleman; a man born with an insatiable desire for knowledge; a man endowed with an unusual intelligence to assimilate facts; a man gifted with an erudite ability to communicate, to speak, to lecture and to teach; and

Whereas, Dr. Vaughn was a man impeccable and meticulous in taste, morals, carriage, dress, protocol, speech and performance; a man inspired by an ambition for the attainment of excellence for excellence sake; a man blessed with humility born of self-confidence that prohibited the thought of self-aggrandizement, greed or selfishness; and

Whereas, Dr. Vaughn was an active member of the Mound City Medical Forum and its president in 1938, a member of the Missouri Pan-Medical Association and the National Medical Association throughout the major portion of the 20th century, and was the first candidate from the City of St. Louis and the State of Missouri to be elected to the office of President of the National Medical Association in 1941; and

Whereas, Dr. Vaughn was one of the first black physicians of the City of St. Louis and the State of Missouri to be accepted into the St. Louis Medical Society and the Missouri State Medical Association and the American Medical Association; and

Whereas, Dr. Vaughn aspired to personally programmed postgraduate study (resident training not being available to black physicians in those days) and attained faculty appointment at St. Louis University School of Medicine in 1949 and the Diplomate of the American Board of Surgery in 1949 and Fellowship in the American College of Surgeons in 1952; and

Whereas, Dr. Vaughn spent a major portion of his surgical career in the training of black and white medical students, interns and residents in clinical surgery at Homer G. Phillips Hospital and St. Louis University School of Medicine, and in 1943 paved the way for the first residents of Homer G. Phillips Hospital to obtain postgraduate medical training in order that they could return to Homer G. Phillips Hospital to head clinical departments; and

Whereas, Dr. Vaughn and his family have been outstanding citizens of the City of St. Louis and the State of Missouri, influential in many civic and social and political programs; and

Whereas, Dr. Vaughn received the 50-year meritorious service award presented by the Missouri State Medical Association sponsored in 1967; and

Whereas, Dr. Arthur N. Vaughn retired from the active practice of medicine in 1970 and deceased February 1974; and, therefore be it

Resolved, That Dr. Arthur N. Vaughn be the recipient of a posthumous citation from the Missouri State Medical Association for his outstanding noteworthy and exemplary contribution to medical education and post-graduate training, particularly in the area of development of black surgical leadership.

(Referred to Reference Committee on Reports of Officers.)

Resolution #38—Constitutional Convention

(Introduced by St. Louis County Medical Society)

Whereas, The current method of election of delegates to Missouri State Medical Association and its Council does not follow current one man, one vote regulation; and

Whereas, Other deliberative bodies have reappointed themselves toward this end; now therefore be it

Resolved, That the Missouri State Medical Association calls for a constitutional convention to reapportion itself.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #39—Health Care Foundation of Missouri

(Introduced by Wilbur P. McDonald, M.D.)

Whereas, Contrary to its Articles and Bylaws, and in contravention of its function and purpose, as described to the Missouri State Medical Association and reported in the minutes of the 115th Annual Meeting of the MSMA, the Health Care Foundation of Missouri has concerned itself with reviewing the "reasonableness" of individual fees, charged by members of the MSMA to their patients, whether or not the physician charging the fee reviewed is a member of the HCFM; and

Whereas, The HCFM has accepted remuneration for so reviewing the reasonableness of individual fees, charged by members of MSMA to their patients whether or not the physician charging the fee reviewed is a member of the HCFM, from insurance companies questioning the reasonableness of such fees, and

Whereas, The HCFM has not followed any authorized and prescribed procedures for hearing or reviewing such cases and has set other nonauthorized procedures not permitted by its Articles or Bylaws for such review, now therefore be it

Resolved, That the Missouri State Medical Association censures the Health Care Foundation of Missouri in these regards, and withdraws its recognition of, and support of, the Health Care Foundation of Missouri.

(Referred to Reference Committee on Resolutions.)

The Speaker then reminded the Delegates that, according to the Constitution and Bylaws, introduction of new resolutions not included in the Delegates Handbook would be in order at the Second Session of the House provided that 200 copies of the resolution or funding for same are made available and presented to the Delegates 24 hours before the meeting, that ten copies be submitted to the Secretary and that introduction of each resolution is approved by a two-thirds vote of the House of Delegates.

The Speaker then introduced Dr. James Brown of Springfield, Vice-Speaker, who made several brief announcements.

The Vice-Speaker also introduced a special guest, Dr. John Chenault of Decatur, Ala., Vice-Chairman of the Board of Trustees of the American Medical Association.

There being no additional business, the Vice-Speaker declared the first session of the House of Delegates adjourned.

SECOND SESSION

Friday, April 5, 1974

The Second Session of the House of Delegates was called to order at 4 PM by Dr. Robert A. Slickman, Speaker, who presided.

Dr. Lytton, Chairman of the Credentials Committee, reported that a quorum was present.

The Speaker invited Dr. R. Stacey Long, Chairman of the Reference Committee on Constitution and Bylaws, to make his report.

CONSTITUTION AND BYLAWS

The Reference Committee on Constitution and Bylaws met on Thursday, April 4, 1974 following the session of the House of Delegates at Crown Center Hotel, Kansas City. All committee members were present.

Council Minutes

The Council minutes from April, 1973 through Wednesday evening, April 3, 1974 were read and approved by the Committee.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion to adopt was approved.)

Resolution #1—Rotation of MSMA Presidency

The next order of business was Resolution #1. The resolution presented three points for consideration:

(1) Whereas, Only three members of St. Louis County Medical Society and Fourth Councilor District have been President of the Missouri State Medical Association in the last 52 years.

(2) Whereas, The rotation of the presidency between Kansas City, St. Louis and Northern and Southern Missouri has systematically excluded our societies.

(3) Whereas, This has been brought to the attention of the Officers and Council of Missouri State Medical Association and no remedial action has been accomplished or proposed, therefore be it

Resolved, (That the St. Louis County Medical Society recommends) that the Bylaws of the Missouri State Medical Association specify that the rotation for presidency of the Missouri State Medical Association include the Fourth District every fifth year.

Mr. Speaker, after considerable discussion from the floor, the Committee rejected Resolution #1.

(The Speaker then called for a vote on Resolution #1. Resolution #1 was not adopted.)

Resolution #5—MSMA Parliamentary Procedure

The next order of business was consideration of Resolution #5. It was the feeling of the Jackson County Medical Society that the work of the House of Delegates should be as uncomplicated, expeditious and efficient as possible and that newer systems of parliamentary procedure seem to lend themselves to these goals more readily than older, traditional systems. Resolution #5 stated that many organizations have discarded the classic *Robert's Rules of Order* in favor of more contemporary systems. The suggestion was made to replace *Robert's Rules of Order* with the most recent edition of *Sturgis Standard Code of Parliamentary Procedure.*

There were no comments on Resolution #5 to support the change and there were no members of the Committee hearing who had any specific knowledge of the advantages of *Sturgis Standard Code of Parliamentary Procedure.*

Mr. Speaker, I recommend that Resolution #5 be referred to the Standing Committee on Constitution and Bylaws for further study.

(The recommendation was considered as a motion to refer by the Speaker. The motion carried.)

Resolution #6—MSMA Specialty Representation

Resolution #6 deals with the representation of medical specialty organizations in the MSMA. It stated that there appeared to be a demonstrable need to strive for unity of purpose and coordination of action in order to respond to the many pressures being brought to bear upon the profession. Resolution 6 recommends an amendment to the Constitution and Bylaws to provide for representation of medical specialties in the House of Delegates and that said representation be limited to two delegates for any medical specialty.

Discussion from the floor brought out the points that this resolution might lead to fragmentation of organized medical uniformity. It also was felt that the additional number of delegates would cause the Association to become unwieldy.

Mr. Speaker, I recommend that Resolution #6 be rejected.

(The Speaker then called for a vote on Resolution #6. Resolution #6 was not adopted.)

Resolution #7—MSMA Council Chairman

Resolution #7 concerns the activities and duties of the MSMA Council Chairman. It refers to the increased activity which has been added to the duties and concerns of the Chairman of the Council, and that the Chairman should be free to concentrate his attention upon the needs of the State Association without concern for activities and problems of his own Councilor District. It further recommends that when a member of the Council is elected Chairman, the District Council seat which he occupied shall be declared vacant and the District shall select a new Councilor.

Discussion from the floor indicated that there were no proponents and that three members of the participating group were Council members who saw no reason for Resolution #7.

Mr. Speaker, I recommend that Resolution #7 be defeated.

(The Speaker called for a vote on Resolution #7. Resolution #7 was defeated.)

Resolution #10—MSMA-Sponsored Group Professional Liability Insurance Program

Resolution #22—Malpractice Insurance

Resolutions #10 and #22 are similar in that they concern MSMA-sponsored group professional liability insurance. Professional liability carriers are refusing to renew contracts or to issue new contracts to several physicians who are members of the Association. Approximately 34 state medical associations now sponsor group professional liability programs.

After considerable testimony and discussion, it was the unanimous feeling of the group that the Council attempt to develop a malpractice program for its members as soon as possible and that a feasibility study be undertaken and adequately funded.

Mr. Speaker, I recommend the adoption of Resolution #22 as written.

(Since Resolution #10 and Resolution #22 are similar, the Speaker ruled that the House vote only on Resolution #22. Resolution #22 was adopted.)

Resolution #38—Constitutional Convention

Resolution #38 concerns the current method of election of delegates to the Missouri State Medical Association and its Council and recommends that the MSMA call a constitutional convention to reapportion itself.

After considerable testimony was heard, it was felt that the problem of representation and reapportionment should be assigned to the Long-Range Planning Committee.

Mr. Speaker, I move that Resolution #38 be referred to the Long-Range Planning Committee.

(The motion carried.)

Mr. Speaker, this concludes the report of the Reference Committee on Constitution and Bylaws.

The Speaker invited Dr. Harold B. Rapp, chairman, to present the report of the Reference Committee on Resolutions.

RESOLUTIONS

The meeting of the Reference Committee on Resolutions was held at 4 PM in the Mission Room, Crown Center Hotel, on April 4, 1974. All members of the Committee were present.

Council Minutes

The Council Minutes assigned to the Resolutions Committee were reviewed by the Committee. They included the meetings in April, June, September and December, 1973 and in February of 1974. They were reviewed and approved by the Committee. The supplementary report dated April 3, 1974 was reviewed and approved.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion was approved.)

The Annual Report of the Health Care Foundation of Missouri for 1974 was reviewed and approved.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion carried.)

The report of the Commission on Medical Economics, Third Party Medicine and Governmental Relations was reviewed and the Committee recommends adoption of this report.

Included in the above report is the following Resolution:

Whereas, Some physicians have been dropping out of the Medicaid Program because of inconsistent payments of services, unrealistic denial of coverage of many services, and retroactive denial of payments; and

Whereas, Many of the services retroactively denied are overhead items to the physician, making it possible for him to actually lose money in the program; and

Whereas, The dentists have a definite fee schedule, and

Whereas, The Welfare recipient in the State of Missouri is finding it increasingly more difficult to find adequate medical care; therefore, be it

Resolved, That the Missouri State Medical Association approves the negotiation of a definite fee schedule and list of ancillary services provided for Title XIX recipients; and be it further

Resolved, That the negotiated fee schedule be renegotiated on an annual basis.

Mr. Speaker, the Committee recommends the adoption of this Resolution.

(The Speaker reread the Resolves for the House of Delegates. After a brief discussion, the vote was taken and the Resolution was approved.)

As a part of the above report, the Committee reviewed the report of the MSMA representative to the Medical Advisory Committee, Missouri Division of Welfare, and approved the report and recommends this for the perusal of all MSMA physicians.

Mr. Speaker, I move the adoption of this portion of the report.

(This portion of the report was adopted.)

Resolution #4—Physician Nonparticipation in PSRO Activities

Resolution #9—Professional Standards Review Organization

Resolution #12—Opposition to PSRO

Resolution #36—Repeal of PSRO Legislation

Mr. Speaker, the Committee heard extensive discussion of Resolutions #4, #9, #12 and #36 and believes that the intent of the discussion is most clearly embodied in Resolution #36. Therefore, the Committee recommends adoption of Resolution #36.

(The Speaker restated the fact that Resolutions #4, #9 and #12 are embodied in Resolution #36 and the Committee recommendation was to adopt Resolution #36. However, Donald E. Kuenzi stated that Clay County Medical Society sponsored Resolution #4 and the Resolves in Resolution #4 do not coincide with the Resolves in Resolution #36. He said that Clay County Medical Society did not feel that this expresses its feeling about the intent of Resolution #4.

The Speaker then called for a vote on Resolution #4. After further discussion, the vote was taken and Resolution #4 failed.

Dr. Rapp then called for a point of order and repeated the Reference Committee's recommendation to adopt Resolution #36.

The Speaker then called for any further discussion on Resolution #36. Dr. Stanley S. Peterson requested that the Speaker give a ruling in regard to if Resolution #36 be passed, will it or will it not establish a policy of the Missouri State Medical Association.

The Speaker replied that the House of Delegates is the policy-making body of the Missouri State Medical Association, and he would interpret passage of this resolution as establishing a policy of the Missouri State Medical Association.

The Speaker then called for a vote on Resolution #36 and it was approved.)

Resolution #15—Discrimination Regulations of the Cost of Living Council

Resolution #21—Cost of Living Council Regulations

The Committee heard discussions relating to Resolution #15 introduced by Greene County Medical Society and Resolution #21 introduced by the Commission on Medical Economics, Third Party Medicine and Governmental Relations. The two resolutions are identical. The Committee further commends the efforts of the Board of Trustees of the American Medical Association in its activities with the Cost of Living Council and requests the Council of the MSMA to so notify the American Medical Association.

Mr. Speaker, the Committee recommends adoption of Resolution #21.

(There was no discussion. The Speaker called for a vote on Resolution #21. Resolution #21 was adopted.)

Resolution #19—Pre-Admission Certification

The Committee reviewed the discussion regarding Resolution #19 relating to Pre-Admission Certification and noted that all physicians of Missouri are opposed to this regulation.

The Committee moves adoption of the Resolution. The Committee also requests the MSMA to commend the American Medical Association for its activities in this regard.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker ruled that the adoption of Resolution #19 and the adoption of this portion of the report be voted on separately. Resolution #19 was adopted. This portion of the report also was adopted.)

Resolution #18—National Health Insurance

The Committee heard discussion regarding Resolution #18 relating to National Health Insurance as proposed by the Greene County Medical Society and offers the following revision:

WHEREAS, The President of the United States as well as many others is now supporting a national health insurance plan; and

WHEREAS, The federal government has produced plans which are designed mainly for cost containment rather than quality medical care; and

WHEREAS, The present system of medical care has resulted in better care for more people; therefore, be it

Resolved, That any system of national health insurance be designed with the consultation and aid of the practicing physicians from the very beginning; and be it further

Resolved, That the welfare of the patient be the guiding principle for this plan; and be it further

Resolved, That all steps be taken to provide a mechanism so that the patient realizes the value of the services to the point of real participation in the payment for those services.

Mr. Speaker, I move the adoption of Resolution #18 as amended by the Committee.

(The Speaker called for the vote and the amended Resolution #18 was adopted.)

Resolution #32—Politics in VA Hospitals

The Committee heard discussion regarding Resolution #32 which was introduced by Richard Bradley, M.D., of St. Louis and recommends adoption of this resolution.

(The Speaker called for the vote on Resolution #32 and it was adopted.)

Resolution #29—Apply PL 92-603 (Sect. 249F) to Government Hospitals in Missouri

Resolution #29 also was introduced by Dr. Bradley and requests application of Section 249-F of Public Law 92-603 to government hospitals in Missouri. The Committee moves adoption of this resolution.

(The Speaker called for the vote on Resolution #29 and it was adopted.)

The Reference Committee commends Dr. Bradley for bringing these two matters to the attention of the House of Delegates.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion was approved.)

Resolution #14—Involvement of Third Parties in the Practice of Medicine

The Committee brought up Resolution #14 for discussion. There was insufficient discussion and no representation and the Committee took no action on this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker ruled that the vote would be on the adoption of Resolution #14 upon which the Committee took no action. Resolution #14 was adopted.)

Resolution #8—Discriminatory Fees

Resolution #8, which was introduced by Mineral Area Medical Society, related to discrimination in fees as based on geographical area. It was discussed at length, and the Committee recommends adoption of this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker asked for any further discussion. After pertinent remarks by Dr. Heeb, the Speaker called for a vote on the adoption of Resolution #8. Resolution #8 was adopted.)

Resolution #20—Physicians' Involvement in Comprehensive Health Planning

After lengthy discussion in regard to Resolution #20 relating to physicians' involvement in comprehensive health planning, the Committee wholeheartedly endorses this resolution and requests adoption of Resolution #20.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #20. After a brief discussion, Resolution #20 was adopted.)

Resolution #39—Health Care Foundation of Missouri

The Committee heard discussion regarding Resolution #39 as introduced by Wilbur McDonald, M.D., St. Joseph, regarding his experiences with the Health Care Foundation of Missouri. After lengthy discussion, it was apparent that the basic problem was lack of communication in an individual case and does not necessarily reflect on the general intent or purposes of the Health Care Foundation.

The Committee recommends disapproval of the resolution.

(The Speaker called for a vote on Resolution #39. There was no discussion. Resolution #39 failed.)

Mr. Speaker, I move the adoption of this report as amended.

(The report as amended was adopted.)

The Speaker invited Dr. B. A. Moranville, Chairman, to present the report of the Reference Committee on Miscellaneous Affairs.

MISCELLANEOUS AFFAIRS

The Reference Committee on Miscellaneous Affairs met in the Westport Room at 3:30 PM on April 4, 1974. The entire committee was present as assigned, with B. A. Moranville as Chairman, presiding. Open discussion was held until 5 PM. The Committee then met until 6 PM.

The Committee considered the report of the Committee on Legislative Affairs and recommended adoption of this portion of the report.

The Committee considered the report submitted by the Commission on Interspecialty Medicine. The Committee recommended the adoption of this portion of the report.

The Committee considered those portions of the Council minutes referred to it for the Council meetings of April 1, 1973, June 2 and 3, 1973, Sept. 29 and 30, 1973, Dec. 15, 1973, Feb. 1, 1974, and April 3, 1974. The Committee recommended the adoption of this portion of the report.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion was approved.)

Resolution #2—Seat Belt Legislation

The Committee considered Resolution #2 introduced by the St. Louis County Medical Society. Subject: Seat Belt Legislation. The Committee recommended the adoption of this resolution with the amendment removing the fourth Whereas and deleting the portion of the second *Resolved*, "make more money available to this state for highway development as well as."

Mr. Speaker, I move the adoption of this portion of the report as amended.

(The Speaker called for any discussion. After discussion, Dr. Charles A. Jost moved that Resolution #2 be further amended by inserting the words "this applies only to the driver of the car" after the words "seat belt." The Speaker then called for the vote on Dr. Jost's amendment to Resolution #2, which was defeated.

The Speaker then called for the vote on the amended Resolution #2 as proposed by the Reference Committee. The amended Resolution was approved.)

Amended Resolution #2, as approved, reads as follows:

Whereas, Annually almost 60,000 people die on the highways in the United States including Missouri; and

Whereas, There is well documented evidence from Australia that the use of seat belts, enforced by law, has reduced this toll by 18%, and

Whereas, Many people, especially the young, do not realize the importance of the use of seat belts; be it

Resolved, That:

1. The House of Delegates of MSMA go on record in favor of a seat belt law being passed by the General Assembly of the State of Missouri, and
2. A copy of this Resolution be sent to all of the members of the General Assembly to encourage them to pass such legislation and thereby, help to protect the citizens of Missouri from injury or death.

Resolution #23—Insurance Coverage for Mental Illness

The Committee considered Resolution #23, which was submitted by Ralph L. Biddy, M.D. of the St. Louis Medical Society. Subject: Insurance Coverage for Mental Illness. The Committee recommends the approval of Resolution #23 as presented.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #23. Resolution #23 was adopted.)

Resolution #24—Drunk Drivers

The Committee considered Resolution #24, which was submitted by Patrick C. Hogan, M.D. of the St. Louis Medical Society. Subject: Drunk Drivers. The committee recommends approval of this resolution as presented.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #24. Resolution #24 was adopted.)

Resolution #25—Reasonable Life Sustenance

The Committee considered Resolution #25, which was submitted by Patrick C. Hogan, M.D. of the St. Louis Medical Society. Subject: Reasonable Life Sustenance. The Committee considered this resolution to be too vague in its present form and, therefore, recommends disapproval of Resolution #25.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for the vote on Resolution #25. Resolution #25 was not adopted.)

Resolution #26—Life Begins at Conception

The Committee considered Resolution 26, which was introduced by Charles A. Jost, M.D. Subject: Life Begins at Conception. The Committee recommends the adoption of this resolution with the addition of the words "a new" between the words "that" and "life," making this "Whereas" read: "Many authorities in the sciences of biology, physiology, anatomy and embryology, agree that a new life begins at the moment of conception," and the addition at the end of the Resolution of the words "and the General Assembly of the State of Missouri."

The amended Resolution #26 would read as follows:

Whereas, The time when an egg cell and a sperm cell unite to form a new cell with a unique heredity is called the moment of conception, and

Whereas, Many authorities in the sciences of biology, physiology, anatomy and embryology agree that a new life begins at the moment of conception, therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association accept the scientific evidence that life begins at the moment of conception, and instruct the Secretary to so inform the Supreme Court of the United States and the General Assembly of the State of Missouri.

(The Speaker called for the vote on Resolution #26 as amended. After an inconclusive voice vote, he asked for a standing vote. The amended Resolution #26 failed by a standing vote of 80 to 89).

Resolution #27—Definition of Life and Death

The Committee considered Resolution #27, which was introduced by Patrick C. Hogan, M.D. Subject: Definition of Life and Death. The Committee recommends disapproval of this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #27. After discussion, Dr. Hogan moved that Resolution #27 be referred to the Commission on Interspecialty Medicine for rewriting. The motion to refer Resolution #27 to the Commission on Interspecialty Medicine failed on a standing vote of 81 to 87.

After discussion, the Speaker called for the vote on Resolution #27 for which the Reference Committee recommended disapproval. On vote, Resolution #27 was disapproved.)

Resolution #28—Legislation to Teach Physiology in Secondary Schools

The Committee considered Resolution #28, which was introduced by Paul L. Friedman, M.D. of the St. Louis Medical Society. Subject: Legislation to Teach Human Physiology in the Secondary Schools. The Committee recommended adoption of this resolution with the amendment of the resolved portion to read:

Resolved, That the House of Delegates of the Missouri State Medical Association call upon the State Board of Education to develop and implement factual, academically founded courses in the school system to teach human physiology and pathophysiology at the elementary and secondary level; and be it further

Resolved, That copies of this resolution be sent to the State Board of Education.

Mr. Speaker, I move the adoption of this portion of the report as amended.

(The Speaker called for a vote on Resolution #28 as amended. Resolution #28 was adopted.)

Resolution #30—Ratify the Equal Rights Amendment

The Committee considered Resolution #30, which was introduced by Paul L. Friedman, M.D. of the St. Louis Medical Society. Subject: the Equal Rights Amendment.

The Committee recommends the adoption of this resolution with an amendment deleting the words "mental disease" from the second Whereas.

Resolution #30, as amended would then read:

> Whereas, Many citizens are denied equal rights before the law because of their sex; and
>
> Whereas, Many of the same citizens suffer because of this denial of rights; and therefore be it
>
> *Resolved,* That this House of Delegates of the Missouri State Medical Association call upon the legislature to ratify the Equal Rights Amendment to the United States Constitution.

Mr. Speaker, I move the adoption of this portion of the report as amended.

(The Speaker called for the vote on Resolution #30 as amended. After discussion, the amended Resolution #30 was adopted.)

Resolution #31—Complete Maternity Coverage

The Committee considered Resolution #31 which was submitted by Hubert A. Ritter, M.D. of the St. Louis Medical Society. Subject: Complete Maternity Coverage.

The Committee recommends adoption of Resolution #31 as written.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for the vote on Resolution #31, which was adopted.)

Resolution #35—Support of House Bill 1254

The Committee considered Resolution #35, which was submitted by Francis X. Lieb, M.D. of the St. Louis Medical Society. Subject: Support of House Bill 1254 (Mental Retardation Legislation). The Committee recommended adoption of this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for the vote on Resolution #35, which was adopted.)

Mr. Speaker, I move the adoption of this report in its entirety as amended.

(The motion was approved.)

The Speaker invited Dr. James M. Stokes, Chairman, to give the report on the Reference Commitee on Medical Education and Public Welfare.

MEDICAL EDUCATION AND PUBLIC WELFARE

Mr. Speaker, the Committee on Medical Education and Public Welfare met at the Crown Center Hotel in Kansas City on Thursday, April 4, 1974 at 3:15 PM. Five members of the Committee were present. The Committee recommends that the reports of the Council be accepted as published in the MSMA Journal from April through December, 1973 and also recommends approval of the reports of the Council of February 1 and April 3, 1974.

(Mr. Speaker, I move the adoption of this portion of the report.

(The motion to adopt this portion of the report was approved.)

The Committee next reviewed the report of the Ad Hoc Commission on Continuing Education and commends Dr. Paul R. Young, Chairman, and the committee for their organizational work and excellent report, which will be important to the State Association in future recertification issues.

Mr. Speaker, I move that this body commend Dr. Paul Young and his Commission for their report by adoption of this portion of the report.

(The motion to adopt this portion of the report was approved.)

Resolution #3—Hospital Medical Staff Autonomy

Mr. Speaker, the Committee reviewed Resolution #3, which was introduced by Clay County Medical Association concerning Hospital Medical Staff Autonomy. After discussion, deliberation and some compromise, it was felt that as it stands, Resolution #3 is so worded as to maximize the differences between physicians and hospitals, and the Committee recommended amendment to this Resolution.

Begin with the first *Resolved,* which is paragraph 5 in Resolution #3. There are four paragraphs beginning with Whereas. The fifth paragraph begins with *Resolved.* This was amended to read as follows:

> *Resolved,* That the House of Delegates of the MSMA upholds the principle of hospital medical staff responsibility for the day-by-day practice of medicine in the hospital for standards of patient care, and also upholds the principle which states that the responsibility for reviewing and maintaining the standards of patient care must remain in the hands of the medical staff with the support of the hospital administration; and be it further
>
> *Resolved,* That the MSMA House of Delegates makes each physician member aware by all available educational means that certain forces in the hospital field are attempting to bring about increased authority of hospital administrations to control private physicians on hospital staffs; and be it finally
>
> *Resolved,* That each member physician of MSMA be urged to be certain that no bylaws changes which are allowed to be effected in the hospitals where he practices which would tend to dilute his responsibility or authority to use his best medical judgment in the care of his patients, consistent with the general standards of care recommended by the medical staff and approved by the governing Board.

(The Speaker called for consideration of the Resolution #3 as amended. Dr. George Ladyman then moved that Resolution #3 be rereferred to the Committee for reconsideration and rewriting. The motion was approved.)

Resolution #13—Hospital Governing Board and Medical Staff Relationship

Mr. Speaker, the next resolution considered by the Committee is out of numerical order. It is Resolution #13, which deals with a similar problem regarding hospital governing board and medical staff relationship. It was introduced by the Greene County Medical Society.

The Committee recommends Resolution #13 for approval by the House of Delegates, excluding the Appendix, which is one full page.

(The Speaker called for a vote on Resolution #13 exclusive of the Appendix. Resolution #13 was adopted.)

Resolution #11—Solicitation by Medical Laboratories

Resolution #11 on Solicitation by Medical Laboratories, was introduced by Greene County Medical Society. The Committee recommends against approval of Resolution #11 as it is worded.

(The Speaker called for the vote on Resolution #11. Resolution #11 failed.)

Resolution #17—Use of Combination Drugs

The Committee considered Resolution #17 on the Use of Combination of Drugs. It was introduced by Greene County Medical Society.

The Committee recommends approval by the House of Delegates. I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #17. Resolution #17 was adopted.)

Mr. Speaker, I move the adoption of this portion of the report and the adoption of the report as a whole.

(The motion to adopt the report was approved.)

The Speaker invited Dr. Paul H. Rother, Chairman, to give the report or the Reference Committee on Reports of Officers.

REPORTS OF OFFICERS

The Reference Committee on Reports of Officers met in the Shawnee Room of the Crown Center Hotel at 3:30 PM on Thursday, April 3, 1974 with all members present.

The remarks of the President, E. A. Stricker, M.D.; the President-Elect, James C. Cope, M.D.; and the President of the Woman's Auxiliary, Mrs. Helen Willman, were accepted and recommended for approval. The Committee wishes to commend the Auxiliary on its very productive year of service.

The reports of the Secretary, Treasurer and Executive Secretary were reviewed, accepted and recommended for approval.

The Minutes of the Council Meetings from April, June, September and December, 1973, and February, 1974, were reviewed and accepted. The Supplementary Report of the Council Meetings of February 1, 1974, and April 3, 1974, were also reviewed and accepted.

The Committee took a special note of the **Resolution Commending Thomas P. Fox**, who retired on April 1, 1974, from his position as Executive Assistant of the Missouri State Medical Association and Assistant Secretary of the Missouri State Medical Foundation. The Committee also would like to add its thanks for his years of service and extend him good wishes, health and happiness for the future.

Mr. Speaker, I move the acceptance of this portion of the report.

(The motion to adopt this portion of the report carried.)

The report of the Committee on Publications was reviewed and accepted. The report of the Committee on Planning, which had previously been accepted by the Council, was reviewed and accepted.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion to adopt this portion of the report was approved.)

The Committee next considered the Resolution of the Council of the Missouri State Medical Association, the resolved of which reads as follows:

Resolved, That Chapter VIII, Section 1(a) of the 1973 Revised Bylaws of the Missouri State Medical Association be amended in line 2 by striking out the figures "$65" and inserting in lieu thereof, the figure "$90" and further amend Section 1(a) in line 3 by striking out the date "1970" and inserting in lieu thereof the date "1975," and be it further

Resolved, that Chapter VIII, Section 1(h) of the 1973 Revised Bylaws of the Missouri State Medical Association be amended on line 3 by striking out the date "1972" and inserting in lieu thereof the date "1975."

The Committee recommends the adoption of this Resolution.

Mr. Speaker, I move the adoption of this portion of the report.

(Noting that this resolution is a change in the Bylaws, the Speaker announced that the resolution would lie on the table for one day and consideration would be deferred until the Third Session of the House of Delegates on Sunday.)

(The motion to adopt this portion of the report carried.)

Resolution #16—Improved Communications with Membership of the MSMA

The Committee next considered Resolution #16 on Improved Communications with the Membership of MSMA, the *Resolved* of which reads as follows:

Resolved, That House of Delegates support the dues increase, and be it further

Resolved, That additional field men be employed to work with the physicians of Missouri in carrying out the business of the organization.

The Committee recommends the adoption of Resolution #16.

(The Speaker called for the vote on Resolution #16, which was adopted).

Resolution #33—Coordination of AMA-ERF Fund Recipient with Practicing Physician

The Committee next considered Resolution #33, Coordination of AMA-ERF Fund Recipient with Practicing Physician. The Committee modified this Resolution by deleting the second *Resolved* so that Resolution #33 now reads as follows:

Resolved, That the House of Delegates of the Missouri State Medical Association hereby recommends that student recipients of loans from the AMA-ERF be assigned to such a physician actively caring for patients, such physician to act as confidant, friend, advisor, and in general, as a representative of organized medicine, and be it further

Resolved, That such assignment shall be made by the Delegate to the AMA from the State in which the school is located, and be it further

Resolved, That the physician so assigned shall agree to maintain the same degree of confidentiality in this relationship that he is accustomed to maintain in his relationships with his patients, and be it further

Resolved, That a copy of this Resolution be transmitted to the House of Delegates and the Board of Trustees of the American Medical Association by the Delegates of this Association to the American Medical Association.

The Committee recommends adoption of this resolution as amended.

(The Speaker called for a vote on Resolution #33. Resolution #33 was adopted as amended.)

Resolution #34—AMA Membership for Medical School Faculty

The Committee next considered Resolution #34, AMA Membership for Medical School Faculty. After much participating discussion, which included the student delegates who were present, the Committee recommends that this resolution not be approved.

(The Speaker called for a vote on Resolution #34. Resolution #34 failed.)

Resolution #37—A. N. Vaughn Citation

The Committee next considered Resolution #37 regarding the N. A. Vaughn Citation. The Committee recommends approval of this resolution honoring a prominent St. Louis black physician.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion, which carried, included approval of Resolution #37.)

Mr. Speaker, I move the adoption of this report in total.

(The motion was approved.)

At this time, Dr. Robert Mayer moved that the House of Delegates reconsider the approval by the House of the Council minutes for April, June, September and December 1973 and February, 1974 in relation to new insurance programs for the membership recommended by the Insurance Study Committee.

(The motion to reconsider was seconded and approved.)

Dr. Hetlage then spoke to the subject of the report of the Insurance Study Committee which was presented at the Council Meeting on April 3, 1973, as follows:

"Dr. Bonebrake, Chairman of the Insurance Study Committee, recommended the following new insurance programs to the Council for their approval: (1) Term life; (2) Overhead; (3) Major Medical."

Dr. Hetlage stated that he felt that the Reference Committee on Reports of Officers was provided insufficient material for proper hearings on the matter and requested that a member of his delegation move to rerefer this particular portion of the Council Minutes of April 3, 1973, back to the Reference Committee for further study and hearings.

Dr. Mayer moved that the portion of the supplementary report of the Council minutes of April 3, 1974 which relates to MSMA insurance coverage be rereferred to the Reference Committee on Reports of Officers.

After discussion, Dr. Rother moved to rerefer this portion of the report to the Council instead of the Reference Committee on Reports of Officers.

(This motion was approved. The Speaker then called for a vote on the acceptance of the remainder of the Council report. The remainder of the Council report was accepted.)

Dr. Rother then moved the adoption of the report in total as amended.

(The motion was approved.)

The Speaker then invited Dr. Caldwell, Chairman, to present the report of the Reference Committee on Necrology.

NECROLOGY

The Reference Committee on Necrology met in the Century Room of the Crown Center Hotel on Thursday, April 4, 1974.

The Reference Committee on Necrology of the Missouri State Medical Association regretfully reports that there have been 93 deaths among members since the 1973 Annual Session, whose names are attached to this report. With this in mind, the Necrology Committee offers the following resolution:

Whereas, There have been 93 deaths among our members since the 1973 Annual Session, and

Whereas, Each of these members is missed as an individual as well as for his contributions to the practice of medicine and to the Missouri State Medical Association, and

Whereas, The loss of each member is keenly felt by all members, his loved ones and close associates and, we are confident, the patients he has served with dedication, and

Whereas, Condolences in the form of the Memoriam Perpetuam have been sent to the immediate family of each deceased member, therefore be it

Resolved, That the same expression of sympathy continue to be sent to each immediate family and be it further

Resolved, That the House of Delegates now pay personal tribute by standing for a moment of silence in memory of each of the 93 members we have lost and whose names will be recorded in the minutes of this Annual Session.

Mr. Speaker, I move that the report of the Reference Committee on Necrology be approved.

(The motion was approved and the Speaker asked the House of Delegates to stand for a moment of silence as indication of approval of the motion.)

Members Deceased Since the 1973 Annual Session

Grunberg, Emile, Columbia
Tibbs, William A., St. Louis
Ketcham, William M., Kansas City
Glenn, Elmer E., Sun City, Ariz.
Thompson, Lawrence D., Columbia
Rohlfing, Walter, St. Louis
Burks, Jess E., St. Louis
Shaw, William J., Fayette
Hickey, Robert F., St. Louis
Knese, Luke A., San Juan Capistrano, Calif.
Benjamin, Durand, St. Louis
Bourke, Timothy, Kansas City
Park, George M., St. Louis
Klaff, Daniel D., St. Louis
Sheahan, Edwin L., Atlanta, Ga.
Richter, William B., Stockton
Pranger, Sylvester H., St. Louis
Eanet, Morton P., Kansas City
Montgomery, James G., Kansas City
Aiken, George A., Marshall
Cooper, Lawrence D., Fort Meyers, Fla.
Neilson, Arthur W., Clayton
Dahms, Gustave, St. Louis
Frerking, Herbert W., St. Louis
Mansur, Edward E., Pompano Beach, Fla.
Jones, James B., Brentwood
Sweany, Henry C., Smyrna, Ga.
Denny, Hubert M., Union
Eber, Carl T., St. Louis
Ibaviosa, Alfred C., Crystal City
Cappel, Powel B., St. Louis
Reynolds, Garland A., Cape Girardeau
Bradley, Frank R., St. Louis
Altringer, Arthur N., Shawnee Mission, Kan.
Levey, Simon A., St. Louis
Willits, Lyle G., Kansas City
Yang, Jae H., St. Louis
McLain, Bobby M., Poplar Bluff
Jones, John B., Columbia
Hart, Martin M., Salem
Weisman, Sol, St. Ann
Goldman, Alfred, St. Louis
Neal, M. Pinson, Columbia
Stein, Leonard P., St. Louis
Kurz, Rudolph F., Alton, Ill.
Boughnou, Harvey P., Kansas City
Ragsdale, George M., Paris
Johnstone, Paul N., Kansas City
Deyton, Jorn W., St. Louis
Langhus, Melvin O., N. Kansas City
Weller, Lynn D., Kansas City
Forster, Armand C., St. Louis
Archer, Perry C., Shelbyville
Bloom, W. A., Fayette
Cohen, Benjamin H., St. Louis
Unger, Harold, Kansas City
Slaughter, Shelby C., Fredericktown
Knight, John S., Shawnee Mission, Kan.
Helm, James O., New Florence
Huet, Raul, Kansas City
Isom, Waldo B., Knox City
Hogue, Frank S., Kansas City
Falk, Oswald P. J., Clayton
Vaughn, A. N., St. Louis
Tremain, Ernest E., Maplewood
Reh, Edward P., St. Louis
McCredken, Samuel R., Excelsior Springs
Kenzler, Jack I., St. Louis
Goldenberg, Sidney, University City
Davis, John J., Overland Park, Kan.
Nussbaum, Paul B., Cape Girardeau
Stansbrough, Raymond A., Normandy
Barnett, Norman H., Joplin

Rutledge, William J., Campbell
Eubank, William R., Kansas City
Lederman, Joseph, St. Louis
Rosen, Max, Springfield
Lucke, Eugene M., Hannibal
Feinstein, Leon A., St. Louis
Papp, Sandor D., Joplin
Heifetz, Carl J., St. Louis
Brasher, Charles A., Mount Vernon
McCubbin, Clarence R., Leawood, Kan.
Knabb, Arthur D., Springfield
McNalley, Frank P., St. Louis
Kimura, Richard Y., St. Louis
Duemler, John H., St. Louis
Swidnicki, Leonid, Bountiful, Utah
Padfield, Earl G., Jr., Kansas City
Senn, Emmett J., Herculaneum
Andersen, Elmer J. T., Montgomery City
Lieberman, B. Albert, Kansas City
Staehle, Melvin E., St. Louis

The Speaker invited new business.

Introduction of New Business

The House of Delegates approved the introduction of Resolution #40 by a two-thirds vote. The resolution was then introduced by Dr. Hubert A. Ritter.

Resolution #40—Unified Membership with the American Medical Association

Whereas, The American Medical Association, a federation of state medical associations, is dedicated to acting in the best interests of all physicians; and

Whereas, The states of Arizona, California, Hawaii, Illinois, Oklahoma, New York and Wisconsin have voluntarily recognized that the strength of our federation is measured by our degree of unity by establishing constitutional policies for unified membership; and

Whereas, The AMA provides services to all state medical associations on an appeal basis without regard to the number of state members who support the AMA through membership; and

Whereas, The AMA House of Delegates at the Clinical Meeting in November, 1972 adopted the policy, "that all state medical associations should be considered having all members support all levels for our national federation by adopting, where possible, the unified concept"; therefore be it

Resolved, That the bylaws of the Missouri State Medical Association be changed so that all members shall also be members of the American Medical Association.

(**Referred to the Reference Committee on Constitution and Bylaws.**)

The House of Delegates approved the introduction of Resolution #41 by a two-thirds vote. The resolution was then introduced by Dr. Hubert A. Ritter.

Resolution #41—Opposition to U. S. Senate Bill 2994 and U. S. House Bill 12053

Whereas, U. S. Senate Bill 2994, known as the National Health Planning and Development Act and U. S. House Bill 12053, sometimes known as the Roy-Rogers Bill, a similar proposal, seems to consolidate many public health services, such as, Comprehensive Health Planning, Regional Medical Programs and Hill-Burton financing and

Whereas, These same bills provide for governor appointed State Health Commissions, similar to that of public utilities, to regulate physicians' charges, license facilities, certify the need for services, review quality of care and set standards and

Whereas, All the authority extended to the governors is through a five-man panel appointed by the Secretary of HEW, and

Whereas, Experience to date in no way revealed state or federal intervention in health care delivery to improve quality or availability of same, now, therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association go on record as opposing enactment of this or similar legislation and that our Congressmen and Senators be so informed, further be it

Resolved, That the AMA be informed of this action by the Missouri State Medical Association.

(**Referred to the Reference Committee on Miscellaneous Affairs.**)

Resolution #42—In-Depth Health Concern

Resolution #43—Oppose Abortion on Demand

Resolution #44—The Beginning of Human Life

Since Resolutions #42, #43 and #44 did not receive a two-thirds vote of approval by the House of Delegates for introduction, their introduction was not allowed and they were not considered by the House. Copies of Resolutions #42, #43 and #44 had been given to the Delegates at the First Session of the House of Delegates on Thursday, April 4, 1974.

At this time, Dr. James Brown, Vice-Speaker assumed the gavel. There being no further business, he adjourned the Second Session of the House of Delegates with the announcement that the Annual Meeting of the Missouri State Medical Foundation would be held immediately following adjournment.

THIRD SESSION

Sunday, April 7, 1974

The Third Session of the MSMA 116th House of Delegates was called to order by the Speaker, Dr. Robert A. Slickman, at 7:30 am in the Century Room of the Crown Center Hotel.

Dr. George J. Lytton, Chairman, gave the report of the Credentials Committee and declared the presence of a quorum. With unanimous consent, the Speaker dispensed with a roll call and the reading of the minutes of the two previous meetings.

Dr. R. Allen Chandler, Chairman, was invited to present a supplementary report from the Council.

Supplementary Council Report

"Mr. Speaker, a special meeting of the Council was held on April 6, 1974 in Room 1139 at 10:30 am.

"Subject for discussion was the report of the Reference Committee on Reports of Officers having to do with the Council's action on the report of the Special Insurance Committee headed by Dr. M. D. Bonebrake.

"Questions were asked as to the specific ability to transfer insurance policy, specifically, the present Major Medical and Nurse Expense to a Major Medical Policy, if desired, which also includes coverage of physicians' fees. Those policies now in effect with riders of disability can be transferred with the same riders attached, if a physician wishes to buy the proposed Major Medical coverage.

"Phoenix Mutual Life Insurance Company, who will be the carrier under the new proposed plan, is rated A-plus 5A which is the highest possible rating afforded an insurance carrier.

"I move the adoption of the supplementary report, Mr. Speaker."

(The Speaker called for discussion. There being no discussion, he called for a vote on the motion to adopt the supplementary report. The motion carried.)

Dr. James A. Reid, Chairman of the Nominating Committee, was invited to present the report of his committee.

NOMINATING COMMITTEE

The Nominating Committee has directed me to submit the following names on the slate of officers for approval by the Association:

Vice-President—Dr. Robert A. Mayer, St. Louis County
Vice-President—Dr. James E. Campbell, Macon
Vice-President—Dr. Frederick J. McCoy, Kansas City
AMA Delegate—Dr. Stanley S. Peterson, Springfield

AMA Alternate Delegate—Dr. James C. Sisk, St. Louis
AMA Delegate—Dr. Rae W. Froelich, Lebanon
AMA Alternate Delegate—Dr. Melvin C. Kasten, Cape Girardeau

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker invited additional nominations from the floor. Hearing none, he entertained a motion that nominations cease and that a unanimous ballot be cast for the slate as presented by the Nominating Committee. The motion was seconded and carried.)

Dr. John I. Matthews, Secretary, announced that the following Councilors had been elected for two-year terms:

Dr. John N. Martin, First District
Dr. Max S. Franklin, Third District
Dr. Robert E. Bregant, Fifth District
Dr. Andrew McCanse, Seventh District
Dr. Claude W. Cooper, Ninth District

At this time, the Speaker invited nominations for the office of President-Elect. Dr. George J. Lytton of Kansas City nominated Dr. R. Allen Chandler of Kansas City. The nomination was seconded by a Delegate and by Dr. Max S. Franklin for the Third Councilor District. A Delegate moved that nominations cease and that Dr. Chandler be elected by acclamation.

(The motion was seconded and approved.)

The President-Elect was escorted to the Speaker's stand where he made a brief acceptance statement. Mrs. Chandler also was escorted to the Speaker's stand.

The Speaker then called for additional reports of reference committees.

Dr. R. Stacey Long, Chairman, was invited to present the additional report of the Reference Committee on Constitution and Bylaws.

CONSTITUTION AND BYLAWS

The Reference Committee on Constitution and Bylaws met at 5:30 PM on Friday, April 5, 1974 with all members present.

Resolution #40—Unified Members of the MSMA With the American Medical Association

The purpose of the meeting was to consider Resolution #40 which was introduced by Dr. Hubert A. Ritter of the St. Louis Medical Society. This resolution proposed unified membership of the MSMA with the American Medical Association.

A suggested amendment to Resolution #40 was adopted by the Committee and reads as follows:

> *Resolved*, That changes in the Bylaws of the MSMA be considered to the effect that all members of the Association shall also be members of the AMA, and be it further
>
> *Resolved*, That the Council of the MSMA be instructed to assure that full and ample discussion of this important issue occur in each of the Councilor Districts and each of the county societies to the end that this Resolution in a formal manner be brought before the House of Delegates at the first session of the 1975 Annual Meeting of this Association.

Mr. Speaker, I recommend the adoption of this amendment to Resolution #40.

(The Speaker asked for approval of the House to consider Resolution #40 as amended by the Reference Committee. There were no objections. He then invited discussion.

Dr. Richard V. Bradley, St. Louis, then moved that Resolution #40 be further amended by inserting the word "Constitution" in the first Resolve *to read as follows:*

UNIVERSITY OF OKLAHOMA, COLLEGE OF MEDICINE—TULSA
Department of Family Practice
— POSITION AVAILABLE —

Head of the Department of Family Practice, University of Oklahoma College of Medicine—Tulsa and Director of the Family Practice Clinic. Applicant should be Board Certified or eligible in family practice or a primary care specialty, with an interest and/or background in teaching.

Send curriculum vitae to:

BRYCE O. BLISS, M.D., CHAIRMAN
FAMILY PRACTICE SEARCH COMMITTEE
121 RANCH ACRES MEDICAL BUILDING
3233 EAST 31ST
TULSA, OKLAHOMA 74128

Resolved, That changes in the Constitution and Bylaws of the MSMA be considered to the effect that all members of the Association shall also be members of the AMA, and be it further

The Speaker then called for a vote on Dr. Bradley's amendment, which was approved.

The Speaker then called for a vote on the adoption of amended Resolution #40 as a whole. He explained that if the resolution were adopted, it would be held over until the 117th Annual Session of the House and then would be voted on. He further explained that approval of Resolution #40 would not actually amend the Constitution but, instead, resolves that consideration be given to amending the Constitution in 1975. He added that if Resolution #40 were adopted by this House and then published in MISSOURI MEDICINE *twice during the coming year, it would allow properly worded amendments to the Constitution and Bylaws to be voted on at the next regular meeting of the House of Delegates (117th Annual Session).*

The Speaker then called for the vote on Resolution #40 as amended. Resolution #40 was adopted as amended.)

The Speaker invited Dr. B. A. Moranville, Chairman, to present the additional report of the Reference Committee on Miscellaneous Affairs.

MISCELLANEOUS AFFAIRS

The Reference Committee on Miscellaneous Affairs met in the Roanoke Room, Crown Center Hotel, at 5:55 PM on April 5, 1974 with four members present.

Resolution #41—Opposition to U. S. Senate Bill 2994 and U. S. House Bill 12053

The Committee considered Resolution #41, which was submitted by Dr. Hubert A. Ritter of St. Louis Medical Society. The Committee recommends approval of this resolution as written.

Mr. Speaker, I move the adoption of this report.

(The Speaker called for the vote on Resolution #41. He invited discussion. There was no discussion. Resolution #41 was then adopted by the House.)

A Delegate then presented the additional report of the Reference Committee on Medical Education and Public Welfare for Dr. James Stokes, Chairman, who could not be present.

MEDICAL EDUCATION AND PUBLIC WELFARE

Resolution #3—Hospital Medical Staff Autonomy

The Reference Committee on Medical Education and Public Welfare met following the meeting of the House of Delegates on April 5, 1974 to consider Resolution #3 as amended.

The Committee recommends adoption of Resolution #3 as amended.

(The Speaker invited discussion. There was none. Since there were no objections to consideration of Resolution #3, he then called for the vote on Resolution #3 as amended. Resolution #3 as amended was adopted.)

There being no additional reports of reference committees, the Speaker called for unfinished business.

Unfinished Business

The Speaker referred to the report of the Reference Committee on Reports of Officers presented at the Second Session of the House, stating that this report contained two amendments to the Constitution and Bylaws which were required to lay on the table for a period of one day.

There being no objection to the action, the Speaker took the two amendments from the table without a vote for consideration by the House of Delegates.

The first amendment to the Constitution and Bylaws to be considered reads as follows:

Resolved, That Chapter VIII, Section 1(b) of the 1973 Revised Bylaws of the Missouri State Medical Association be amended in Line 2 by striking out the figures "$65" and inserting in lieu thereof the figure "$90" and further amend Section 1(a) in Line 3 by striking out the date "1970" and inserting in lieu thereof the date "1975."

The second amendment to the Constitution and Bylaws to be considered reads as follows:

Resolved, That Chapter VIII, Section 1(b) of the 1973 Revised Bylaws of the Missouri State Medical Association be amended on Line 3 by striking out the date "1972" and inserting in lieu thereof the date "1975."

(The Speaker invited discussion. There being no discussion, the Speaker called for a vote on the adoption of both Resolves, *stating that adoption of the two Resolutions would require a two-thirds vote of the House. Both Resolutions were adopted as amendments to the Constitution and Bylaws.)*

The Speaker invited any further unfinished business. There being none, he invited new business.

NEW BUSINESS

The Speaker called next for new business and invited Dr. E. A. Stricker, retiring President, to the podium. Dr. Stricker made the following remarks:

"I am sure that most of you are aware of the recent action taken by the appropriate committees of the United States Congress in refusing to extend wage-price controls in a limited area of the economy, which, of course, involved doctors and hospitals. I feel certain that the membership of MSMA agrees with this action, and I believe that it is the general consensus of most economists, government officials and the general public that unrealistic controls cause severe economic and social distortions which ultimately do not work to the public good. Let us, as physicians in the future, as well as in the past, always be aware of the public need and the public good.

"I congratulate you, the membership, for your cooperation and efforts to date. While you cannot live apart from the economic effects of the times, I encourage your vigorous efforts in support in combatting the common enemy, inflation. Let us, in the health care field, voluntarily exert our best efforts to restrain rising costs to the greatest extent possible and consistent with the delivery of the finest medical care that is possible to bring to your patients and the public.

"I invite further discussion to determine if we might give this to the news media, if they so wish."

The Speaker then expressed appreciation to Mrs. Herbert Mantz for serving as Parliamentarian for the House of Delegates.

Installation of Officers

The Speaker invited the Officers and Councilors to stand in front of the podium where the Association Secretary, Dr. John I. Matthews, administered the oath of office.

At this time, the Speaker turned the gavel over to Dr. James Brown, Vice-Speaker, who recognized MSMA Vice-President Rae Froelich of Lebanon who spoke to the subject of the responsibility and function of the Association vice-presidents.

There being no further business, the Vice-Speaker invited President James C. Cope to announce his commission and committee appointments for the 1974-1975 year. Members whose terms had not expired were not mentioned and it is assumed that they will continue to serve.

Committee Appointments

Committee on Constitution and Bylaws—Frederick D. Peterson, St. Louis (term to expire in 1977) and Joseph A. Conrad, Chillicothe, Chairman for the 1974-1975 year.

Committee on Legislative Affairs—John I. Matthews, Jefferson City, Chairman; R. Allen Chandler, Kansas City; James C. Cope, Columbia; Robert E. Bregant, Jefferson City; and Max S. Franklin, St. Louis (one year terms).

Committee on Planning—Charles P. McGinty, Cape Girardeau; James C. Cope, Columbia; Paul H. Rother, St. Charles, Chairman for 1974-1975.

Committee on Voluntary Health Agencies—William C. Allen, Columbia, Chairman (term expires in 1977).

Commission Appointments

Commission on Public Affairs—Joseph B. Kendis, St. Louis; Frank McCory, Springfield; Dr. Donald R. Germann, Kansas City; Allen P. Klippel, St. Louis; James D. Grable, Portageville (terms to expire in 1977); Richard P. Bowles, Liberty, Chairman for 1974-1975.

Commission on Medical Economics, Third Party Medicine and Government Relations—John Torontow, Nevada; Charles W. Chastain, Farmington; John A. Griffith, Kansas City; E. Warren Allen, Carrollton; John M. Laird, St. Louis County (terms to expire in 1977); Stanley S. Peterson, Springfield, Chairman for 1974-1975.

Commission on Continuing Education and Health Manpower—Edwin K. Burford, Cape Girardeau; Robert B. Dikeman, St. Louis; W. Thomas Morgan, Jr., West Plains; W. Wayne Boydston, Odessa; Marvin A. Singleton, Joplin (terms to expire in 1977); George H. Ladyman, Poplar Bluff, Chairman for 1974-1975.

Commission on Medical Legal Affairs—Joseph S. Cope, Lexington; Jerome I. Simon, St. Louis; Irving H. Clark, Kansas City; Vincente D. Deles, Crystal City; George P. Wilson, Columbia (terms to expire in 1977); Frederick J. McCoy, Kansas City, Chairman for 1974-1975.

Commission on Interspecialty Medicine—It is the policy for the President of our Association to appoint representatives of the special organizations making up the Commission on Interspecialty Medicine as recommended by the specific organizations. Some of these organizations

Commission on Interspecialty Medicine—(The name of the Representative will be followed by the name of the Alternate.) *Missouri Society of Pathologists,* Henry C. Allen, St. Louis and David L. Zacharias, Kansas City; *Missouri State Allergy Association,* T. W. Bryan, St. Louis and Clarence C. Coors, Moberly; *Missouri State Society of Neurological Surgeons*—Howard J. McAlhany, Springfield and Charles K. Whittaker, Kansas City; *Missouri Society of Internal Medicine,* William H. Ames, St. Joseph; *Missouri Society of Thoracic Surgeons,* Richard W. Yore, St. Louis and Charles L. Roper, St. Louis; *Missouri Ophthalmological Association*—Anwar Shah, St. Louis and Wilbur H. Lewin, St. Louis; *Missouri State Surgical Association*—Cyril J. Costello, St. Louis and John A. Griffith, Kansas City; *Missouri Psychiatric Association*—Robert D. Brooks, St. Louis and James Young, Kansas City; *Missouri Chapter, American Academy of Pediatrics,* Francis X. Lieb, St. Louis and Donald S. Overend, Springfield.

MSMA Treasurer Donald Judd *(left)* and Council Chairman Max S. Franklin.

The Speaker requested an invitation for the meeting place of the next Annual Session of the Association. On behalf of St. Louis and St. Louis County Medical Society and St. Louis County Medical Society, Dr. Richard V. Bradley invited the MSMA to hold the 1975 Annual Session in St. Louis. The invitation was accepted.

There being no additional business, the Vice-Speaker declared the 116th Annual Session adjourned.

Give now to your student loan fund!

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MISSOURI STATE MEDICAL FOUNDATION

113 Madison, Jefferson City, Missouri 65101

REGISTRATION AT THE 116TH ANNUAL SESSION

First Councilor District—65

Acuff, R. Philip, St. Joseph
Allen, E. Warren, Carrollton
Arst, H. E., Kansas City
Bauman, Henry C., Maryville
Beck, Paul M., St. Joseph
Bohnsack, Ralph W., Brookfield
Broyles, Watkins A., Bethany
Christ, Martin H., St. Joseph
Cofer, T. N., Chillicothe
Cook, Jerry W., Kansas City
Conrad, Joseph A., Chillicothe
Craig, Owen W. D., St. Joseph
Cross, Albert D., Trenton
Dernoncourt, John E., Smithville
Dixon, John R., Brookfield
Dunshee, R. E., Maryville
Edwards, Theodore F., North Kansas City
Fisher, Joseph L., St. Joseph
Fotopoulos, C. K., North Kansas City
Freeman, Jerry C., Kansas City
Fuson, L. H., St. Joseph
Fuson, William A., Trenton
Gearhart, Merriam, Bethany
Gilani, A., North Kansas City
Gilliland, Charles E., Cameron
Goldberg, I. E., Braymer
Hayes, Paul W., St. Joseph
Hedges, Richard C., Excelsior Springs
Hendren, Thomas, North Kansas City
Herman, Allen I., St. Joseph
Imes, E. D., Maryville
Jackson, W. R., Maryville
Jimenez, Jose, St. Joseph
Kuenzi, Donald E., Kansas City
Latimer, Walter N. A., Kansas City
McDaniel, John R., St. Joseph
McDonald, Wilbur P., St. Joseph
McPhee, W. R., Kansas City
Mandler, George, Chillicothe
Martin, John N., St. Joseph
Matteson, Frank B., Grant City
Moen, B. H., St. Joseph
Morgan, Troy, Albany
Nixon, Edward E., Gallatin
Ozenberger, L. A., Plattsburg
Petersen, H. E., St. Joseph
Pileggi, F. A., Kansas City
Rapp, Harold B., Cape Girardeau
Redmond, William, St. Joseph
Ridings, Harold D., Cape Girardeau
Riordan, Robert H., Kansas City
Rost, William B., St. Joseph
Schertz, T. B., North Kansas City
Sklenar, Don, St. Joseph
Soper, William D., Excelsior Springs
Sportsman, W. L., Smithville
Stacy, Winton T., St. Joseph
Trinidad, Hermanito R., Chillicothe
Vandiver, V. D., Chillicothe
Wadlow, Ernest E., St. Joseph
Weed, Randal, St. Joseph
Whitsell, O. Earl, St. Joseph
Willman, Charles R., St. Joseph
Willumsen, Henry C., St. Joseph
Wolff, P. G., Cape Girardeau

Second Councilor District—13

Bach, Lysle M., Hannibal
Buben, R. W., Hannibal
Campbell, James E., Macon
Cohrs, C. C., Moberly
Davis, Landis Y., Canton
Fleming, J. Will, Jr., Moberly
Fleming, Tom, Moberly
Foreman, Phillip B., Hannibal
Hall, Stanley G., Hannibal
Lewellen, Charles H., Louisiana
Plowman, Edward M., Hannibal
Stuart, Dan, Brunswick
Tarvydas, Francis, Edina

Third Councilor District—85

Alexander, Frazier D., St. Louis
Allen, Henry C., Webster Groves
Anglo, Luis B., St. Louis
Aylward, H. J., St. Louis
Baue, Arthur E., St. Louis
Biddy, Ralph L., St. Louis
Bilsky, Nathan, St. Louis
Block, Arnold S., St. Louis
Bohigian, George, St. Louis
Bowen, S. F., Jr., St. Louis
Bradley, Richard V., St. Louis
Brennan, George A., St. Louis
Brookes, Robert D., St. Louis
Bryan, William T. K., St. Louis
Cherre, Charles J., St. Louis
Collins, John A., St. Louis
Cooper, Thomas J., St. Louis
Costello, Cyril, St. Louis
Coxe, William S., St. Louis
Criscione, James S., Kirkwood
Dames, Richard, St. Louis
Evens, Ronald, St. Louis
Fallon, Richard H., St. Louis
Finnegan, Joseph V., St. Louis
Franklin, Max S., St. Louis
Fraser, Daniel M., St. Louis
Friedman, Paul L., St. Louis
Geise, August W., St. Louis
Grindon, Joe B., St. Louis
Gunn, Walter T., St. Louis
Haddock, James N., Clayton
Hawkins, George L., St. Louis
Heins, James N., St. Louis
Herman, Morris, St. Louis
Hill, George J., II, University City
Hogan, Patrick C., St. Louis
Hollo, Vencel W., St. Louis
Holtz, Alan S., Kirkwood
Jost, Charles, Florissant
Judd, Donald, St. Louis
Kaskie, Clifford R., St. Louis
Kellett, John, St. Louis
Kelley, Robert W., St. Louis
Kelly, John J., St. Louis
Kerr, David N., Clayton
Kowert, Edward H., St. Louis
Lang, John J., St. Louis
Lawton, Lawrence M., Creve Coeur
Lieb, Francis X., St. Louis
Link, Alexander J., St. Louis
Lottes, J. Otto, St. Louis
McAdam, C. Rush, St. Louis
McAlister, William H., St. Louis
Macdonald, William C., St. Louis
Max, Paul F., St. Louis
Miller, Robert N., Frontenac
Mueller, Robert, St. Louis
Murphy, Michael G., University City
O'Neal, Lawrence W., St. Louis
Paletta, Theodore L., St. Louis
Pernoud, Michael F., St. Louis
Quick, Richard T., St. Louis
Reich, Harry A., St. Louis
Ritter, H. A., St. Louis
Schoenberg, Harry W., St. Louis
Shah, Anwar, St. Louis
Sherwin, Charles S., St. Louis
Sletten, Ivan W., Kirkwood
Spalding, Donald G., St. Louis
Steinberg, Franz U., St. Louis
Stokes, James M., St. Louis
Stoneman, William, St. Louis
Sullivan, Clement J., St. Louis
Thiel, J. Allen, St. Louis
Thoma, George E., Clayton
Tichenor, Robert W., St. Louis
Trotter, Francis O., Jr., St. Louis
Turner, C. M., St. Louis
Ulett, George, St. Louis
Vacca, Joseph B., St. Louis
Wacker, Leo L., St. Louis
Webb, M. A., St. Louis
Williams, Carol F., St. Louis
Yap, Mardonio, St. Louis
Zografakis, George, St. Louis

Fourth Councilor District—53

Bailey, William H., St. Louis
Balster, Vernon H., St. Louis
Boles, C. Read, Clayton
Bolinske, Robert E., St. Louis
Callahan, D. E., Bridgeton
Canty, Eugene J., St. Charles
Crawford, Katherine J., Clayton
Crider, Russell J., St. Charles
Cunningham, E. J., St. Louis
Damron, E. O., Elsberry
Davis, E. W., St. Louis
Deitchman, Robert B., St. Louis
Deles, Vicente D., Crystal City
DelPizzo, Ferdinand, St. Charles
Donley, Leo F., St. Louis
Donnell, H. E., De Soto
Drews, Robert C., Clayton
Ehrlich, Carl F., Creve Coeur
Felder, James P., St. Chalres
Finkel, B. W., Jennings
Forsman, W. W., St. Louis
Hammes, Bob, St. Charles
Hampton, Oscar P., Jr., St. Louis
Hetlage, L. P., Troy
Hoelscher, Harold F., Warrenton
Klippel, Allen P., St. Louis
Kopp, Jules H., St. Louis
Laird, John M., Jr., Florissant
Lewin, W. Howard, St. Louis
Luehrs, R. O., Clayton
McGinnis, William F., St. Louis
Magness, Guy N., University City
Maravilla, L. M., St. Louis
Mayfield, J. L., Crystal City
Mayer, Robert A., Ballwin
Middleton, Jerry N., St. Louis
Miller, Charles, Kirkwood
Ohlms, David L., St. Louis
Peterson, Frederick D., St. Louis
Richardson, W. R., Union
Rother, Paul H., St. Charles
Ruhling, Rudy, St. Louis
Schmidt, Charles A., Gerald
Schwartz, Melvin M., St. Louis
Sisk, James, Clayton
Shea, James G., Washington
Sutter, Richard A., St. Louis
Talaban, Raymundo D., Fredericktown
Viers, Wayne A., St. Louis
Whitener, Miles C., St. Louis
Whitener, Paul R., St. Ann
Workman, George, Hermann
Wyatt, Lois C., Kirkwood

Fifth Councilor District—72

Allen, W. C., Columbia
Almond, Carl, Columbia
Anderson, Philip, Columbia
Asel, Norman D., Columbia
Baker, A. Sherwood, Columbia
Bowe, Edwin, Jefferson City
Bradley, William W., Centralia
Bregant, Robert, Jefferson City
Clark, Kendall A., Jefferson City
Cooper, Charles W., Jefferson City
Cope, James C., Columbia
Cottey, John H. Mexico
Davis, David, Columbia
Dyer, Gary A., Coumbia
Ekern, H, Peter, Mexico
Exon, C. S., Jefferson City
Foote, Jerry, Columbia
Fuchs, George J., Columbia
Garner, Royal S., Jefferson City
Giffen, Lawrence E., Jefferson City
Gordon, James S., Jefferson City
Guhleman, Henry V., Jefferson City
Hall, C. Robert, Versailles
Hart, William M., Columbia
Jolly, Ben N., Mexico
Joseph, Donald J., Columbia
Kanagawa, Harold K., Jefferson City
Kays, Kenneth M., Columbia
Keown, Kenneth, Columbia
King, Robert J., Columbia
Landhuis, Leo R., Columbia
Logue, John T., Columbia
McCaffree, Mary, Jefferson City
Marco, Philip J., Columbia
Marienfeld, Carl, Ashland
Marshall, William G., Glasgow
Matthews, John I., Jefferson City
Mayer, William D., Columbia
Meinershagen, C. W., Jefferson City
Metzgar, Marshall T., Columbia
Mitchell, F. L., Columbia
Mitchell, L. D., Columbia
Moranville, B. A., Columbia
Morgan, Philip E., Columbia
Mosby, Larry D., Columbia
Nieuwenhuizen, Maarten, Columbia
Overholser, M. D., Columbia
Payne, David, Columbia
Robb, Harold, Jefferson City
Ryan, Thomas J., Jefferson City
Sanders, J. S., Jefferson City
Schokker, Johannes, Jefferson City
Scott, E. David, Jefferson City
Scott, Kenneth F., Jr., Oceanside, Calif.
See, William B., Columbia
Senhauser, Donald A., Columbia
Shull, Don, Jefferson City
Siu, Kenneth K. C., Jefferson City
Spratt, J. S., Columbia
Stephenson, Hugh E., Columbia
Struessel, Kenneth, Columbia
Stuart, Byron M., Boonville
Tanner, Robert H., Jefferson City
Theobald, Sterling, Camdenton
VanVranken, Eugene E., Jefferson City
Wallace, Ed S., Mexico
Washburn, J. Loren, Versailles
Watts, Byron, Jefferson City
White, Joseph M., Columbia
Wilson, George P., Columbia
Winn, George W., Boonville
Young, Paul R., Columbia

Sixth Councilor District—37

Block, J., Sedalia
Boydston, Catherine, Odessa
Bradshaw, W. D., Clinton
Boydston, Wayne, Odessa
Braverman, E. M., Sedalia
Cole, William R., Sedalia
Cooper, R. Lee, Warrensburg
Cope, J. S., Lexington
Crayton, Billy G., Waverly
Eklund, A. W., Pleasant Hill
Elhassani, S. B., Sedalia
Giesler, D. H., Osceola
Griffin, O. A., Buffalo
Hobbs, George H., Warrensburg
Kelling, Jordan, Waverly
King, Richard H., Clinton
LaHue, W. C., Lexington
Lamy, John E., Sedalia
Lederer, Charles M., Warrensburg
Lowe, A. L., Sedalia
McBurney, C. Alex, Slater
McCann, Louis P., Nevada
McCorkle, E. Lee, Marshall
McFadden, Gene A., Waverly
Maddox, A. R., Sedalia
Magee, Robert L., Eldorado Springs
Maxson, T. Reed, Warrensburg
Pearse, Roy W., Jr., Nevada
Raynor, Richard C., Marshall
Reid, James A., Marshall
Riley, Charles T., Richmond
Stauffacher, C. Gordon, Sedalia
Torontow, R. John, Nevada
Wetzel, Gus S., Clinton
Wheeler, Robert L., Harrisonville
Worley, Charles A., Sweet Springs
Wray, Rolla B., Nevada

Seventh Councilor District—172

Ahercrombie, Keith J., Shawnee Mission, Kan.
Ames, Mary B., Kansas City
Arms, Arnold V., Kansas City
Asher, Grahham, Kansas City
Ashley, John T., Kansas City
Averill, Keith, Kansas City
Baer, Alvin J., Kansas City
Barnett, Gordon P., Shawnee Mission, Kan.
Bass, Lewis N., Kansas City
Beard, William J., Lee's Summit
Benoit, Hector W., Jr., Kansas City
Berenson, Sheldon E., Kansas City
Bergmann, V. H., Kansas City
Biggs, Alfred D., Jr., Kansas City
Borsuk, Gregory M., Kansas City
Boyer, Philip A., Kansas City
Brumm, L. W., Kansas City
Bruner, Rohert E., Kansas City
Bryant, T. J., Kansas City
Buchanan, Barbara, Kansas City
Buhler, Victor B., Kansas City
Caldwell, John K., Kansas City
Case, William F., Kansas City
Chandler, R. Allen, Kansas City
Coffey, Ralph R., Kansas City
Cotton, Thomas R., Kansas City
Curran, Desmond, Shawnee Mission, Kan.
Curran, Kevin E., Kansas City
Curts, Calvin J., Kansas City
Deeken, James, Kansas City
Devins, George, Kansas City
Dlahal, Luke J., Jr., Kansas City
Dorsch, E. H., Independence
Drowns, Bruce V., Kansas City
Elias, David J., Independence
Elliott, R. Glenn, Kansas City
Engelmann, C. E., Kansas City
Engleman, Reinhold, Kansas City
Eubank, David F., Raytown
Everett, James E., Kansas City
Fairchild, Robert C., Kansas City
Farney, Jacob P., Kansas City
Feist, George V., Kansas City
Ferris, Carl R., Kansas City
Forsythe, Rohert, Kansas City
Fowler, Fred D., Kansas City
Fritzlen, Thomas J., Kansas City
Fuhrman, Donald L., Kansas City
Geha, Braham, Kansas City
Germann, Donald R., Leawood, Kan.
Gist, W. W., Kansas City
Goldman, Stanley, Kansas City
Goodson, William H., Jr., Kansas City
Graham, Wallace H., Kansas City
Griffith, John A., Kansas City
Growdon, J. A., Kansas City
Grunt, Jerome, Kansas City
Guastello, M. J., Kansas City
Hagar, David L., Raytown
Hall, Ralph, Kansas City
Hardy, John W., Kansas City
Haight, J. Max, Kansas City
Haith, Edward E., Kansas City
Hazen, Robert M., Kansas City
Heilman, Edward J., Kansas City
Hickerson, William H., Independence
Hink, Fred W., Independence
Hoadley, William D., Shawnee Mission, Kan.
Hoeper, Sam D., Grandview
Hollweg, Kenneth C., Kansas City
Hughes, Mike, Kansas City
Huse, William J., II, Kansas City
Hyde, L. L., Kansas City
Jacohs, Walter H., Kansas City
Jansen, Rohert, Kansas City
Johnson, Dallas A., Kansas City
Johnson, Richard L., Kansas City
Jonas, Harry S., Independence
Jones, Gale O., Kansas City
Jones, Samuel T., Kansas City
Justus, John B., Kansas City
Kahn, Marvin, Kansas City
Kandt, Ray, Kansas City
Kantor, Samuel, Kansas City
Kelling, Douglas, Overland Park, Kan.
Kyger, John, Independence
Landers, Burnell, Independence
Leitch, Cecil G., Blue Springs
Lindgren, Carleton J., Kansas City
Link, Vance E., Independence
Linville, Howard E., Kansas City
Long, Stacy, Kansas City
Lytton, George J., Kansas City
McAfee, Gordon, Kansas City
McCallister, Ben D., Kansas City
McCanse, Andrew, Kansas City
McConahay, David R., Kansas City
McCoy, Frederick J., Kansas City
McDonald, Herhert L., Kansas City
McDonnell, John F., Kansas City
McGannon, Paul T., Kansas City
McKeel, Thomas B., Kansas City
McVay, James R., Kansas City
MacGee, Edwin, Kansas City
MacInnis, Florence E., Kansas City
Masucci, Joseph, Kansas City
Melgaard, S. Ross, Kansas City
Miller, Gerald L., Kansas City
Moreano, Armando, Kansas City
Mullen, Leo, Kansas City
Nickson, Charles E., Jr., Kansas City
Nohack, Richardson K., Kansas City
Ost, Mark D., Kansas City
Owens, Richard L., Kansas City
Ozar, Milton B., Kansas City
Pakula, Sidney F., Kansas City
Peterson, Carl M., Kansas City
Pierron, Jchn B., Kansas City
Pucci, G. L., Kansas City
Pugh, R. G., Independence
Raich, Rohert A., Kansas City
Reed, William A., Shawnee Mission, Kan.
Reister, Dorothy D., Shawnee Mission, Kan.
Reister, Philip D., Kansas City
Richany, S. F., Shawnee Mission, Kan.
Richert, Robert C., Kansas City
Rose, Charles W., Kansas City
Russell, James L., Kansas City
Sahates, Felix N., Kansas City
Samuelson, Edward A., Kansas City
Sanders, Donald C., Kansas City
Santoro, Carlos G., Kansas City
Sauer, Gordon C., Kansas City
Schmidt, C. Robert, Kansas City
Schottman, G. W., Kansas City
Sells, Kenneth J., Kansas City
Shapiro, L. M., Kansas City
Shelden, Russell D., Kansas City
Shireman, K. L., Kansas City
Shmock, C. L., Kansas City
Singleton, John M., III, Kansas City
Slickman, R. A., Kansas City
Smith, J. Michael, Kansas City
Smith, Wallace B., Independence
Sneid, Philip, Kansas City
Sprinz, Helmuth, Kansas City
Stacey, Wallace, Independence
Stelmach, Walter J., Kansas City
Strihling, Tom, Independence
Szahados, Ernest D., Independence
Tarson, S. S., Overland Park, Kan.
Thomas, Chris, Kansas City
Throne, E. M., Kansas City
Troeh, M. Richard, Independence
Trowhridge, Barnard C., Kansas City
Trowhridge, E. H., Jr., Kansas City
Twohy, G. F., Kansas City
Underwood, Dick H., Kansas City
Van Buskirk, William C., Kansas City
Vaughn, Jim, Kansas City
Wade, Frederick E., Kansas City
Waxman, Herhert J., Leawood, Kan.
Weir, Rohert K., Kansas City
White, Charles H., Prairie Village, Kan.
Wicks, Ed., Kansas City
Wilhelm, Warren F., Kansas City
Williams, George P., Kansas City
Willoughhy, James, Kansas City
Withers, Orval R. Kansas City
Youll, Donald V., Kansas City
Youmans, R. A., Kansas City
Zacharias, David L., Kansas City

Eighth Councilor District—63

Anderson, Paul B., Neosho
Anthony, Dallas D., Springfield
Ashley, Thomas, Springfield
Back, Donald K., Springfield
Barnhill, Floyd, Springfield
Bauer, Harold, Springfield
Beisner, Donald H., Springfield
Bentley, John D., Springfield
Bonehrake, M. D., Springfield
Brown, Jim, Springfield
Callaway, Guy D., Sr., Springfield
Callaway, Guy, Jr., Springfield
Carroll, Thomas W., Lamar
Chase, Ned B., Joplin
Christianson, Charles S., Mt. Vernon
Clarke, Michael J., Springfield
Cruz, Sergio, Jr., Monett
DeTar, D. E., Joplin
Edison, John M., Springfield
Esther, John, Joplin
Ferguson, John P., Springfield
German, Walter A., Springfield
Glover, Kenneth, Mt. Vernon
Graves, Arthur, Mt. Vernon
Griffin, Evelyn, Buffalo
H'Doubler, F. T., Jr., Springfield
H'Doubler, Peter B., Springfield
Huewe, Doug, Springfield
Isaac, Anita M., Springfield
Ivy, Berry, Springfield
Kenney, Roy E., Neosho
Knahh, Kenneth E., Springfield
LeFevre, Philip V., Springfield
Lewis, Noel R., Springfield
Lockhart, Charles E., Springfield
Loeb, Richard, Springfield
Lorenc, Ernest, Springfield
McAlhany, Howard, Springfield
McCraw, Doyle, Bolivar
McNeel, Lee A., Jr., Greenfield
Macdonnell, Thomas M., Marshfield
Pence, F. Wendell, Carthage
Peterson, Stanley S., Springfield
Prater, Bill G., Springfield
Robinson, Gary L., Springfield
Roper, Stanley D., Ozark
Russell, Earl D., Springfield
Schaeffer, E. M., Springfield
Schroff, Carle, Springfield
Schwartz, E. J., Springfield
Shackter, Bruce, Springfield
Singleton, Marvin, Joplin
Spalding, David L., Springfield
Sturtevant, H. N., Springfield
Sweeney, Thomas P., Nixa
Walker, William M., Springfield
White, Ned, Springfield
Williams, John W., Jr., Springfield
Wittmer, S. C., Springfield
Wommack, Fred L., Crane
Wood, George H., Carthage
Wyrsch, Leo M., Springfield
Yancey, Daniel L., Springfield

Ninth Councilor District—12

Bass, B. J., Salem
Cooper, Claude W., Thayer
Elders, Frank A., Cuha
Feind, E. E., Rolla
Froelich, R. W., Lehanon
Hasek, James A., Mountain Grove
Russell, Barhara E., Rolla
Smith, C. Franklin, Willow Springs
Spears, Joe L., Cahool
Stricker, E. A., St. James
Wall, Joe A., Houston
Wiles, Jack N., West Plains

Tenth Councilor District—26

Arat, Metin, Farmington
Bolton, Rohert, St. Louis
Caldwell, Fred, Poplar Bluff
Carlson, E. C., Poplar Bluff
Chapman, Jean A., Cape Girardeau
Chastain, C. William, Farmington
Cozean, Charles H., Cape Girardeau
Dettmer, Robert F., Ironton
Dunmire, George, Kennett
Farmer, Norma, Farmington
Hanshrough, E. T., Poplar Bluff
Hansen, A. L., Butler
Heeh, Max A., Sikeston
Hill, Ronald T., Dexter
Jung, J. Marshall, Cape Girardeau
Karraker, Alvan, Farmington
Kasten, Melvin C., Cape Girardeau
Ladyman, George, Poplar Bluff
McDonald, E. F., Jackson
McGinty, Charles P., Cape Girardeau
Miller, David V., Poplar Bluff
Ramirez, R. M., Poplar Bluff
Rao, A. R., Fredericktown
Rodriguez, Gregorio, Charleston
Ruff, T. E., Poplar Bluff
Till, Bennie N., Poplar Bluff

Guest Physicians—69

Barhero, Giulio J., Columhia
Barnett, James R., Bellevue, Wash.
Berlinger, Norman T., New York, N. Y.
Bierlein, K. J., Pittshurg, Kan.
Bluefarh, S. M., Chicago, Ill.
Brown, Thomas A., Columhia
Brunidor, Josephine G., Kansas City
Cailliet, Rene, Los Angeles, Calif.
Chenault, John M., Decatur, Ala.
Chow, Stanley, Fort Scott, Kan.
Collins, Robert F., N. Hollywood, Calif.
Crawford, John E., Alhuquerque, N. M.
Culver, Warren T., Lawrence, Kan.
Dash, Ira R., St. Louis
Durst, Rohert D., Topeka, Kan.
Euis, David, Creve Coeur
Fellows, Richard, Englewood, N. J.
Fortune, Cedric B., Olathe, Kan.
Galin, Miles, New York, N. Y.
Gallett, Lester E., Bloomington, Minn.
Hartwright, James, Kansas City
Jewell, William R., Kansas City, Kan.
Kamath, P. V., Kansas City
Kulkarni, Archana, Kansas City
Leslie, Stephen A., Overland Park, Kan.
Mussell, Howard, Ashland
Nagel, Eugene, Palos Verdes Estates, Calif.
Nigro, D. M., Kansas City
Nora, Paul F., Evanston, Ill.
Peterson, Charles R., Columhia
Pierce, George, Kansas City, Kan.
Queruhin, Rache P., Kansas City
Rajanna, K., Kansas City
Rehman, Malik A., Kansas City
Rohr, J. H., Mission, Kan.
Rojas, Teofilo, Kansas City
Rothwang, L. Johann, Kansas City
Rush, Charles A., Jr., Ft. Worth, Tex.
Schafé, Mir K., Western Germany
Schotland, Edward, Kansas City, Kan.
Schuetz, Perry N., Shawnee Mission, Kan.
Senior, Rohert M., St. Louis
Slavin, Raymond G., St. Louis
Smith, Laurie, Creve Coeur
Smith, R. L., Longview, Wash.
Spevak, Jack, Des Moines, Iowa
Stechschulte, Daniel J., Kansas City, Kan.
Steele, Clarence H., Kansas City, Kan.
Stradford, H. Todd, Columhia
Stuher, Jack L., Kansas City
Tokrisna, Aphiraks, Independence

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Lewis, Richard P., Columbus, Ohio
Lipman, Bernard S., Atlanta, Ga.
McCanse, Lynn, Kansas City
McCluer, Shirley, Columbia
Maitra, Anita, Kansas City
Marsh, George B., Jr., Grand Saline, Tex.
Tripp, Richard C., Fort Dodge, Iowa
Vickery, Eugene L., Lena, Ill.
Weisman, Maxwell, Baltimore, Md.
Wherritt, Holman R., Kansas City
Whitley, Douglas M., Overland Park, Kan.
Melia, B. J., Jr., Prairie Village, Kan.
Mir, A. R., Kansas City
Moore, Jack D., Shawnee Mission, Kan.
Moyer, Ronald P., Leawood, Kan.
Wilson, Stewart M., Jr., Kansas City
Wright, James H., Kansas City
Young, Robert A., Cedar Rapids, Iowa

There were 598 members, 69 guest physicians, 122 exhibitors, 144 Woman's Auxiliary members, 100 guests registered and 20 staff members. Total registration was 1,053.

116TH ANNUAL SESSION EXHIBITORS

Academia Book Exhibits, Fairfax, Va.
Armour Pharmaceutical Company, Phoenix, Ariz.
Astra Pharmaceutical Products, Inc., Worcester, Mass.
Blue Cross-Blue Shield, Kansas City
Boehringer Ingelheim Ltd., Elmsford, N. Y.
Bristol Laboratories, Syracuse, N. Y.
Clinical Laboratories of St. Louis, Inc., Creve Coeur
Coca-Cola USA, Chicago, Ill.
Data Service Agency, Inc., Maryland Heights
The Emko Company, St. Louis
Encyclopaedia Britannica, Inc., Chicago, Ill.
The Key Company, St. Louis
Lakeside Laboratories, Inc., Milwaukee, Wis.
Lancet Medical Industries, Inc., Portland, Ore.
Medical Plastics Laboratory, Inc., Gatesville, Tex.
The Medical Protective Company, Fort Wayne, Ind.
3M Electronic Business Equipment, Inc., Kansas City
Munns Medical Supply Co., Inc., Topeka, Kan.
North American Pharmacal, Dearborn, Mich.
Pfizer Laboratories, Chicago, Ill.
Pitney-Bowes, Inc., Kansas City
Postal Investment Company, Inc., Jefferson City
Rowell Laboratories, Inc., Baudette, Minn.
Sandoz Pharmaceuticals, East Hanover, N. J.
W. B. Saunders Company, Philadelphia, Pa.
Schering Laboratories, Kenilworth, N. J.
Missouri Seven-Up Bottlers, North Kansas City
Southern Medical Association, Birmingham, Ala.
Tab Products Company, St. Louis
United Medical Equipment Co., Kansas City
United States Air Force Medical Services, Washington, D. C.
The Upjohn Company, Kalamazoo, Mich.

In lieu of Exhibits, the following firms made cash donations to assist in the sponsorship of Scientific Sessions:

Geigy Pharmaceuticals, Ardsley, N. Y.
Eli Lilly and Company, Indianapolis, Ind.
Merck Sharp & Dohme, West Point, Pa.
E. R. Squibb and Sons, Inc., Princeton, N. J.

Dr. Doyle C. McCraw of Bolivar *(left)* visits with Dr. Kenneth Glover of Mount Vernon. Both have been active members of the MSMA for many years.

Dr. Henry C. Allen of Webster Groves *(left)* and Dr. Jordan Kelling of Waverly have another "annual session visit." Dr. Allen and Dr. Kelling interned together in St. Louis.

Missouri State Medical Foundation

Minutes of the Annual Meeting
Crown Center Hotel, Kansas City
April 5, 1974

The meeting was called to order by Byron M. Stuart, M.D., President. A quorum was declared present. Dr. Stuart stated that the minutes of the 1973 Annual Meeting in St. Louis, which immediately followed the Friday afternoon, March 30 Session of the MSMA House of Delegates, had been published in the July 1, 1973 issue of Missouri Medicine. It was moved and seconded that the minutes of the 1973 meeting be approved as published. The motion carried.

Dr. Stuart directed attention to the financial statement of the Foundation as of Dec. 31, 1973, a copy of which was offered to those in attendance and which reads as follows:

FINANCIAL STATEMENT FOR THE YEAR 1973

LENNERTSON & COMPANY
Certified Public Accountants
ST. LOUIS, MISSOURI 63144

January 28, 1974

Missouri State Medical Foundation
113 Madison
Jefferson City, Missouri 65101

Gentlemen:

An examination was made of the Balance Sheet of the Missouri State Medical Foundation, a non-profit Missouri corporation, for the year 1973. The Balance Sheet at December 31, 1973 is on a cash basis and the additions and deductions for the year are set forth in Exhibit A.

Recorded receipts for the year were traced in total into the bank account as deposits and paid checks were seen for the disbursements. A direct confirmation was received from the depository in verification of the cash balances on deposit.

A summary of the loans to medical students follows:

Loans Receivable January 1, 1973	$420,383.01
Loans made during the year	78,450.00
Total	$498,833.01
Less Loan Repayments	18,660.35
Less Loans Written Off	2,500.00
Loans Receivable December 31, 1973	$477,672.66

Positive confirmations were mailed as of September 15, 1973 by the Foundation on 267 individual loans which we had received positive confirmations in 1972. On 33 new loans and 8 loans not previously confirmed we mailed positive confirmations with requests to return the confirmations direct to the auditors. Of the 308 loans, 287 were confirmed for a total of $444,663.58 out of total loans of $477,672.66. No additional loans were made after September 15, 1973.

The Foundation has set up a reserve for losses on student loans in the amount of .05% monthly on the outstanding loan balances. An addition of $2,854.98 was made for the year 1973 and two loans were charged off leaving a reserve balance of $2,754.76 at December 31, 1973. Interest income on loans is recorded on a cash basis and the amount received in 1973 was $5,988.30. Accrued interest on outstanding loans at December 31, 1973 amounted to $35,885.02 and is not included in the loan balances in Exhibit A.

Interest received on the savings account and the certificates of deposit amounted to $1,599.29. The certificates of deposit in the amount of $44,083.51 had earned $1,838.33 of interest at December 31, 1973 which will be recorded on the books when received in 1974.

The Foundation received $31,499.63 from the Dr. Richard S. Battersby Estate. This is shown on Exhibit A under contributions.

The Missouri State Medical Foundation incurred the following expenses for the year ended December 31, 1973:

State Registration Fee	$ 1.00
Professional Fees	529.90
Office Expense	2.20
Printing	169.60
Office Furniture	611.80
Addition to Reserve for Losses	2,854.98
Total	$4,169.48

U. S. Treasury Department form 990 and Schedule A will be prepared for the year 1973 and are due for filing by May 15, 1974. The Foundation is not liable for Federal Income Taxes as it is classified as a Tax Exempt Charitable Organization.

We have examined the Balance Sheet of Missouri State Medical Foundation as of December 31, 1973, prepared on the cash basis. The examination was made in accordance with generally accepted auditing standards and include such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. Since the Balance Sheet is on the cash basis, no opinion is expressed on the attached statement as accrued interest on loans of $35,885.02 and $1,838.33 of accrued interest on certificate of deposit is not shown.

Yours very truly,
Lennertson & Co.
Certified Public Accountants

Exhibit A

Missouri State Medical Foundation
Balance Sheet (Cash Basis), December 31, 1973

Assets

Cash		
Checking Account	$ 24,423.63	
Savings Account #05842586	18,123.28	
Certificate of Deposit #A83068 due 1-15-74	15,000.00	
Certificate of Deposit #A83088 due 3-8-74	10,000.00	
Certificate of Deposit #A80038 due 1-7-74	19,083.51	
Total Cash		$ 86,630.42
Loans Receivable from Medical Students	$477,672.66	
Less Reserve for Losses	(2,754.76)	474,917.90
		$561,548.32

Fund Reserve

Balance January 1, 1973		$485,108.58
Additions and Deductions for Year 1973		
Interest on Loans	$ 5,988.30	
Interest on Bank Deposits	1,599.20	

Members who have regularly attended the Annual Sessions recognize this scene—Thomas P. Fox, MSMA Executive Assistant, and his wife and volunteer helper, Dorothy, who were always "on call" at the Convention Office. Mr. Fox, who has been a member of the staff since 1961 and has served as Assistant Secretary of the MSMF, retired on April 1.

Contributions (see below)	33,756.63	
Assessment of Members, Active $10.00	39,265.00	80,609.13
Total		$565,717.71
Less Expenses for Year		(4,169.48)
		$561,548.32

Contributions

Richard S. Battersby Estate	$31,499.63
Woman's Auxiliary to Buchanan County	165.00
Woman's Auxiliary to M.S.M.A.	300.00
Woman's Auxiliary to Jackson County	150.00
Max S. Franklin, M.D.	100.00
Woman's Auxiliary to Clay County Christmas Project	238.00
Boonville Medical Group	100.00
Miller's Medical Art Pharmacy, Boonville, Mo.	100.00
Sub Total	32,652.63
Contributions under $100.00 each	1,104.00
Total Contributions	$33,756.63

Speaking for the MSMF, Dr. Stuart expressed appreciation for the generous support and contributions of the Woman's Auxiliary to the MSMA. He suggested that the need for the MSMF student loans increased with current inflation and a fourth medical school in the state and commended the MSMA for continuing its assessment for the MSMF for three more years.

Dr. Stuart then called for the next order of business which was election to the Board of Trustees. He asked Dr. George Bohigian, Chairman, to present the report of the Nominating Committee.

Dr. Robert H. Tanner, Jefferson City, was elected to the Board of Trustees to serve a five-year term by a unanimous vote.

Dr. James C. Cope, incoming President of the MSMA, was unanimously elected as an Ex Officio Member of the Board to replace Dr. E. A. Stricker, retiring MSMA President.

Dr. George Mandler, Chillicothe, then presented a check for $200 to the MSMA for Dr. Donald M. Dowell, Chillicothe, who was unable to attend the meeting due to illness. The check was a contribution from the Grand River Medical Society.

The President then called for introduction of new business. There being no new business, he announced that a short meeting of the MSMF Board of Trustees would immediately follow the Annual Meeting of the Missouri State Medical Foundation.

The meeting was adjourned.

Minutes of the MSMF Board of Trustees Meeting Crown Center Hotel, Kansas City Friday, April 7, 1974

The meeting of the Board of Trustees of the Missouri State Medical Foundation was called to order by Byron M. Stuart, M.D., President, immediately after the adjournment of the Annual Meeting.

The first order of business was the election of officers. On behalf of the Nominating Committee, Dr. George Bohigan, Chairman, nominated the following slate of officers for one-year terms:

President—Albert D. Cross, M.D., Trenton, former Vice-President of the MSMF

Vice-President—Kenneth C. Hollweg, M.D., Kansas City

Secretary-Treasurer—Charles R. Doyle, M.D., St. Louis

It was moved, seconded and approved that these officers be elected by acclamation.

Mr. Ron Ellison, Jefferson City, was appointed Assistant Secretary to assist in the administration of the Foundation's program. He will replace Mr. Thomas P. Fox, who will retire.

At this time, Dr. Stuart extended congratulations to Dr. Cross who assumed the Chair.

The next order of business was discussion of a method for solicitation of contributions from the full membership of the MSMA. It was moved that members be encouraged to make personal contributions and memorial donations and to include the MSMF in their last will and testament through communications published in Missouri Medicine. The motion was seconded and approved.

Dr. Cross next introduced the subject of the recommendation of the MSMA Council for a revised loan interest schedule. Mr. Fox then discussed the interest schedule as it was revised in 1970, suggesting that the effect of this revision could not be evaluated until 1975. After further extensive discussion of possible interest rates, it was moved that action on revising interest rates for MSMF student loans be deferred one year. The motion was seconded and carried.

The next subject to be considered was the increased overhead distribution charged by the MSMA. After discussion, it was moved and seconded to accept the overhead distribution of $6,600. The motion carried.

At this time, Dr. Stuart expressed his personal appreciation and that of the Board of Trustees to Mr. Thomas Fox for his many years of dedicated service to the MSMF.

There being no further business, the meeting was adjourned.

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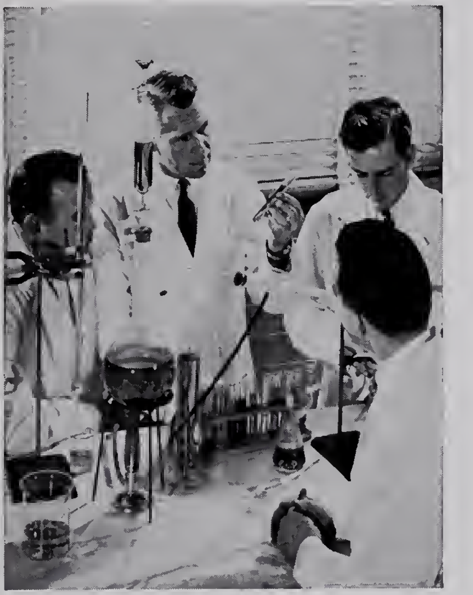

(The following letter was received on Oct. 1, 1971 from a physician who, as a student, received financial assistance from the Missouri State Medical Association members who have contributed to the Missouri State Medical Foundation. It is printed with his permission.)

Dear Doctor:

"Thank you very much for your thoughtful letter concerning receipt of my final payment on my medical student loan.

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The Council Reports

Meeting of April 7, 1974

James C. Cope, M.D., Columbia, President, called the meeting to order. Those present were Drs. Cope; R. Allen Chandler, Kansas City; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; E. A. Stricker, St. James; Walter T. Gunn, St. Louis; R. A. Slickman, Kansas City; John N. Martin, St. Joseph; Max S. Franklin, St. Louis; Louis P. Hetlage, Troy; Robert Bregant, Jefferson City; Andrew McCanse, Kansas City; Howard J. McAlhany, Springfield; Claude Cooper, Thayer; E. T. Hansbrough, Poplar Bluff; Joseph V. Finnegan, St. Louis; William C. Allen and William D. Mayer, Columbia; Richardson K. Noback, Kansas City; J. Loren Washburn, Versailles; Hubert A. Ritter, St. Louis; Messrs. Allen D. Smith, Kansas City; Roger Weis, Kansas City; Hollister S. Smith, St. Louis; Lee Mortenson, Chicago; Ray McIntyre, Royal O. Cooper, Cork Swarens and Ron Ellison, Staff.

President Cope opened the meeting and introduced the new Councilor from the 7th District, Dr. Andrew McCanse of Kansas City.

Dr. Max S. Franklin was elected Chairman of the Council by acclamation and, thereby, became the presiding officer.

MSMA President James C. Cope and President-Elect R. Allen Chandler visit after the Council meeting which followed the adjournment of the 116th Annual Session on April 7.

Dr. Howard J. McAlhany was elected Vice-Chairman of the Council, Dr. Donald R. Judd was elected Treasurer and Dr. John I. Matthews was elected Secretary.

FINANCE COMMITTEE

Dr. Franklin made the following appointments to the Finance and Budget Committee for 1974-75: Drs. Judd, Chairman; Cope, Chandler, Franklin, McAlhany, Hetlage and Martin.

NEXT COUNCIL MEETING

The next meeting of the Council will be held on Friday night, May 24 and Saturday, May 25 at the Downtown Holiday Inn, Jefferson City.

Dr. Gunn thanked the Councilors, Officers and staff for their cooperation and for the privilege of working with them during his tenure in the various offices.

President Cope indicated that the Health Care Foundation of Missouri has applied to HEW to become a statewide PSRO support center and would like MSMA endorsement. He stated that he would write such a letter of endorsement to HCFM.

LEGISLATIVE LIAISON COMMITTEE

Dr. Cope named the following to the Legislative Liaison Committee to work with the state administration on various health and medical related issues: Drs. Cope, Chairman; Bregant and Matthews.

Dr. William D. Mayer presented information regarding public information tapes which the University of Missouri is contemplating using on various radio stations in the state. These are five-minute tapes which would inform the public on various health matters. Dr. Mayer asked for Council endorsement of such a project.

It was suggested that, perhaps, the tapes would be more meaningful in a given area, if a local physician gave a brief introduction to them. It was pointed out that most radio stations would be glad to do this.

On motion of Dr. Hetlage, duly seconded, it was agreed that the MSMA cooperate with the University of Missouri in its request for endorsement of this project, noting the suggestions made by the Council regarding local physician introduction.

Mr. McIntyre reported that he had received a letter from Robert Enlow of the AMA Circulation and Records Department regarding our possible cooperation in a fund-raising project for AMA-ERF. It was pointed out in the letter that the AMA would develop a "personalized" letter and circular which could be sent to each physician over the signature of the President of the Association, Dean of the Medical School, etc. to influence the physicians to give an additional special contribution to AMA-ERF for their choice of one of the AMA-ERF projects.

It was moved, seconded and carried that the MSMA accept the proposal of the AMA and that the President of the MSMA send a letter to the membership and that AMA be notified accordingly.

Dr. Franklin indicated that the Ad Hoc Committee on Family Planning, chaired by Dr. Hetlage, would be continued for the year 1974-1975.

Dr. Hetlage discussed the Ad Hoc Committee on Governmental Relations which is to be under the auspices of the Commission on Medical Economics. It was pointed out that the Chairman of the Commission should appoint this ad hoc committee.

PUBLICATIONS COMMITTEE

Dr. Joseph Finnegan reported that the Publications Committee held a meeting on Saturday, April 6. It was indicated that in the past, osteopathic members of MSMA have been designated in the roster issue as D.O.s without any designation for M.D. members. A complaint was received regarding this practice. However, the Committee felt it necessary that some designation be made and recommended that the present practice be continued.

On motion, duly seconded and carried, it was agreed to accept the recommendation of the Committee regarding D.O. designation in the roster issue of Missouri Medicine.

Dr. Finnegan reported that time was spent by the Publications Committee discussing the decrease in advertising in the Journal and, at the same time, the increase in printing costs. The Committee did not arrive at any definite solution to the problem. Some of the suggestions were that we explore the possibility of combining our Journal with several of those from surrounding states. Different sources of advertising might also be tapped. It was suggested that if individual Councilors and Officers have suggestions regarding various advertising sources, please notify the MSMA Office, as a letter has already been prepared that can be sent to them.

EDITORIAL BOARD

Dr. Finnegan suggested that a supplementary appointment be made to the Editorial Board; Dr. Mary B. Ames, St. Joseph. On motion, duly seconded, Dr. Ames was appointed to the Editorial Board.

UNIFIED MEMBERSHIP WITH AMA

Dr. Slickman reminded the Council that the resolution relating to Unified Membership with AMA, which had been introduced into the House of Delegates, was passed as follows:

Resolved, That changes in the Constitution and Bylaws of the MSMA be considered to the effect that all members of the Association shall also be members of the AMA and be it further

Resolved, That the Council of the MSMA be instructed to assure that full and ample discussion of this important issue occur in each of the Councilor Districts and each of the county societies to the end that this Resolution in a formal manner be brought before the House of Delegates at the first session of the 1975 Annual Meeting of this Association.

Dr. Slickman pointed out that since this calls for a constitutional change, this must be brought to the attention of the entire membership at least twice within the next year. Mr. McIntyre stated that in addition to publishing this to the membership, it also could be sent to each society president for discussion at various county medical society meetings. It was pointed out that the standing Committee on Constitution and Bylaws will need to make specific wording recommendations for changes in the Constitution and Bylaws to provide for unified membership with the AMA for action of the House of Delegates at the 1975 Annual Session.

The meeting was adjourned.

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**117th MSMA Annual Session
April 17-20, 1975, St. Louis**

Missouri Medicine

THE JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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Editor

Purposes of Association

THE PURPOSES of the Missouri State Medical Association are to bring into compact organization the entire medical profession of the State of Missouri with the view of the extension of medical knowledge and the advancement of medical science, to promote and elevate the standards of medical education and the enactment and enforcement of just medical and public health laws, to encourage friendly intercourse among physicians, to guard and sustain measures of interest and advantage to the public and the medical profession and to promote science, knowledge and skill among the medical profession.

1950 MSMA Handbook
Centennial Issue

How to Use This Directory

This Directory includes two rosters of physicians who are members of the Missouri State Medical Association.

The **Roster of Members by County Societies** on page 430 lists each county medical society in alphabetical order, the members of each county medical society and their **street addresses.**

If you are seeking a street address and do not know to which county medical society a member belongs, turn to the **Alphabetical Roster of Members** on page 413 which lists that member's name and the community in which he lives.

Locate the name of that community in the **Guide to County Medical Societies** on page 411 which tells you the county in which that community is located and the county medical society to which that member normally would belong.

The **Roster for the Woman's Auxiliary to the MSMA,** beginning on page 453, lists the officers, directors, committee chairmen, MSMA Advisory Council, presidents of county auxiliaries, districts, state past-presidents and members of each county auxiliary.

For other departments, please refer to the table of contents on the cover page.

Missouri State Medical Association

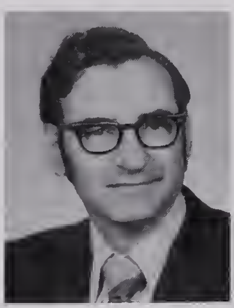
1974-1975 Officers

James C. Cope
President

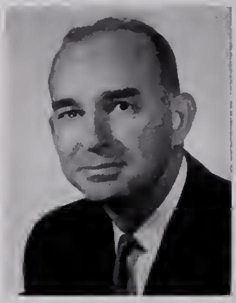
R. Allen Chandler
President-Elect

E. A. Stricker
Immediate Past-President

Robert A. Mayer
Vice-President



James E. Campbell
Vice-President



Frederick J. McCoy
Vice-President

John I. Matthews
Secretary

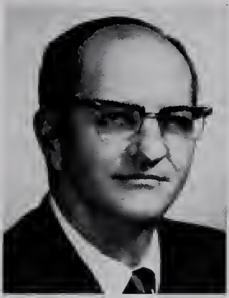
Donald Judd
Treasurer

Robert A. Slickman
Speaker

James T. Brown
Vice-Speaker

AMA Delegates

Stanley S. Peterson
(1973-1974, 1975-1976)



J. Loren Washburn
(1973-1974)

Hector W. Benoit, Jr.
(1974-1975)

Rae W. Froelich
(1975-1976)

Hubert A. Ritter
(1974-1975)

Alternate Delegates

James C. Sisk
(1973-1974, 1975-1976)

Rae W. Froelich
(1973-1974)

Hugh E. Stephenson, Jr.
(1974-1975)

Melvin C. Kasten
(1975-1976)

Lawrence W. O'Neal
(1974-1975)

The Council

John N. Martin
1st District

Lysle M. Bach
2nd District

Max S. Franklin
3rd District
Chairman

Louis P. Hetlage
4th District

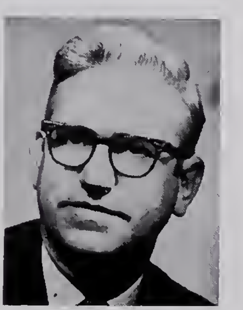
Robert E. Bregant
5th District

William D. Bradshaw
6th District

Andrew McCanse
7th District

Howard J. McAlhany
8th District
Vice-Chairman

Claude W. Cooper
9th District



Eugene T. Hansbrough
10th District

MSMA Committees and Commissions 1974-1975

STANDING COMMITTEES

Executive Committee—James C. Cope, Columbia, Chairman; R. Allen Chandler, Kansas City; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; Max S. Franklin, St. Louis; Howard J. McAlhany, Springfield (1975).

Constitution and Bylaws—Joseph Conrad, Chillicothe, Chairman (1975); Edwin M. Powell, Springfield (1975); R. Stacy Long, Kansas City (1976); Donald R. Judd, St. Louis (1976); Frederick D. Peterson, St. Louis (1977).

Publication Committee—Joseph V. Finnegan, St. Louis, Chairman; William C. Mixson, Kansas City; Charles S. Sherwin, St. Louis; Byron M. Stuart, Boonville; Wilfred E. Wooldridge, Springfield (1975).

Legislative Affairs—John I. Matthews, Jefferson City, Chairman; R. Allen Chandler, Kansas City; James C. Cope, Columbia; Robert E. Bregant, Jefferson City; Max S. Franklin, St. Louis (1975).

Planning—Paul H. Rother, St. Charles, Chairman (1978); Hector W. Benoit, Jr., Kansas City (1975); David N. Kerr, St. Louis (1975); Oral B. Crawford, Springfield (1976); James A. Hasek, Mountain Grove (1976); William D. Bradshaw, Clinton (1977); J. Will Fleming, Moberly (1977); T. N. Cofer, Chillicothe (1978); Charles P. McGinty, Cape Girardeau (1979); James C. Cope, Columbia (1979).

Voluntary Health Agencies—William C. Allen, Columbia, Chairman (1977); Carl Siegel, Kansas City (1975); Melvin A. Cassel, St. Louis (1975); Joseph L. Fisher, St. Joseph (1976); Paul S. Quinn, Springfield (1976).

STANDING COMMISSIONS

Public Affairs—Richard P. Bowles, Liberty, Chairman (1976); Troy Morgan, Albany (1975); R. A. Ritter, Jr., Cape Girardeau (1975); C. Keith Whittaker, Kansas City (1975); Stanley G. Hall, Hannibal (1975); J. E. Block, Sedalia (1975); Byron E. Watts, Jefferson City (1976); Hubert A. Ritter, St. Louis (1976); James C. Denninghoff, Columbia (1976); Richard A. Sutter, St. Louis (1976); Francis M. Corry, Springfield (1977); Donald R. Germann, Kansas City (1977); James D. Grable, Portageville (1977); Joseph Kendis, St. Louis (1977); Allen Klippel, St. Louis (1977).

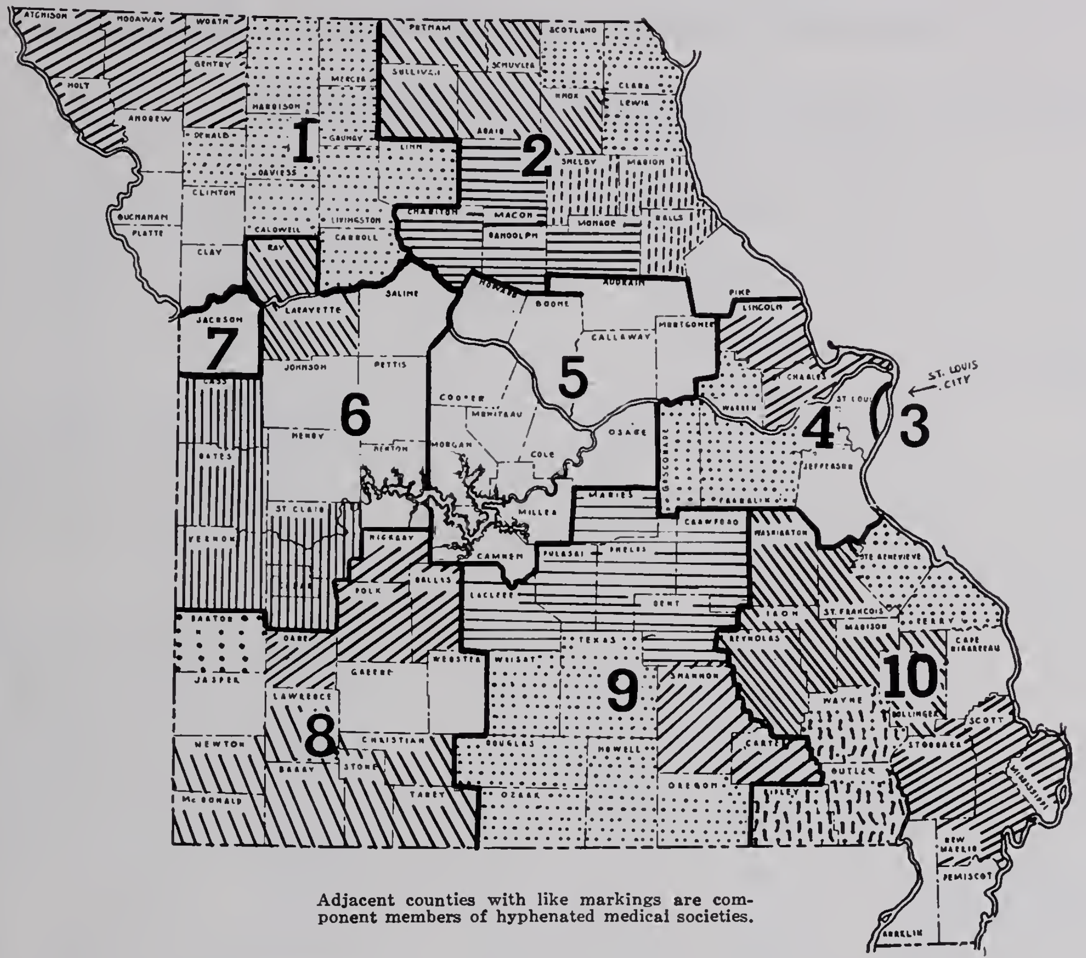
Medical Economics, Third Party Medicine and Governmental Relations—Stanley S. Peterson, Springfield, Chairman (1975); Francis M. Maple, Springfield (1975); Victor B. Buhler, Kansas City (1975); Mark D. Eagleton, St. Louis (1975); E. E. Wadlow, St. Joseph (1975); Herbert C. Wiegand, St. Louis (1976); Max A. Heeb, Sikeston (1976); Kenneth K. Keown, Columbia (1976); E. J. Cunningham, Jr., Ballwin (1976); Rae W. Froelich, Lebanon (1976); John Torontow, Nevada (1977); Charles W. Chastain, Farmington (1977); E. Warren Allen, Carrollton (1977); John M. Laird, Florissant (1977); John A. Griffith, Jr., Kansas City (1977).

Continuing Education and Health Manpower—George H. Ladyman, Poplar Bluff, Chairman (1975); H. Peter Ekern, Mexico (1975); B. J. Bass, Salem (1975); Paul R. Young, Columbia (1975); Lucien W. Ide, St. Joseph (1975); Andrew McCanse, Kansas City (1976); A. Sherwood Baker, Columbia (1976); Richard J. Dames, St. Louis (1976); John C. Soucy, St. Charles (1976); Charles A. Worley, Sweet Springs (1976); Robert Dettmer, Ironton (1977); Robert B. Deitchman, St. Louis (1977); Marvin A. Singleton, Joplin (1977); W. Thomas Morgan, Jr., West Plains (1977); W. Wayne Boydston, Odessa (1977).

Medical-Legal Affairs—Irving H. Clark, Kansas City, Chairman (1977); Lee T. Ford, Jr., St. Louis (1975); Robert V. Tompson, Moberly (1975); Wilbur P. McDonald, St. Joseph (1975); Harold B. Rapp, Cape Girardeau (1975); William R. McPhee, Kansas City (1975); David W. Brown, Springfield (1976); Francis X. Paletta, St. Louis (1976); Frederick J. McCoy, Kansas City (1976); Bernard Draper, Rolla (1976); Robert L. Willcoxon, Joplin (1976); Joseph S. Cope, Lexington (1977); Jerome I. Simon, St. Louis (1977); Vicente D. Deles, Crystal City (1977); George P. Wilson, Columbia (1977).

Interspecialty Medicine—Missouri State Surgical Society, Cyril Costello, St. Louis, Chairman; Missouri Society of Pathologists, Henry C. Allen, Clayton; Missouri State Allergy Association, Clarence Cohrs, Moberly; Missouri State Society of Neurological Surgeons, Howard J. McAlhany, Springfield; Missouri Society of Internal Medicine, William H. Ames, St. Joseph; Missouri Ophthalmological Society, Inc., Anwar Shah, St. Louis; Missouri Psychiatric Association, Robert D. Brookes, St. Louis; Missouri Chapter, American Academy of Pediatrics, Francis X. Lieb, St. Louis; Missouri Dermatological Society, Gordon C. Sauer, Kansas City; Federation of Missouri Urologists, Karl J. Kurtz, Kansas City; Missouri OB-GYN Society, William F. McGinnis, St. Louis; Missouri Radiological Society, Tom W. Staple, St. Louis; Missouri Chapter, American College of Surgeons, G. Lynn Krause, St. Louis; Physical Medicine and Rehabilitation, Robert W. Allen, Columbia; Missouri Academy of Family Physicians, Charles A. Molden, St. Louis; St. Louis Society of Neurological Sciences, Herbert E. Rosenbaum, St. Louis; Missouri Thoracic Society, Peter W. Kinsella, Richmond Heights.

Councilor Districts and Counties in Each District



Adjacent counties with like markings are component members of hyphenated medical societies.

DISTRICT	COUNCILOR	COUNTIES
First	**John N. Martin, M.D.** St. Joseph	Andrew, Atchison, Buchanan, Caldwell, Carroll, Clay, Clinton, Daviess, De Kalb, Gentry, Grundy, Harrison, Holt, Linn, Livingston, Mercer, Nodaway, Platte and Worth
Second	**Lysle M. Bach, M.D.** Hannibal	Adair, Chariton, Clark, Knox, Lewis, Macon, Marion, Monroe, Pike, Putnam, Ralls, Randolph, Schuyler, Scotland, Shelby and Sullivan
Third	**Max S. Franklin, M.D.** (Chairman) St. Louis	St. Louis (City)
Fourth	**Louis P. Hetlage, M.D.** Troy	Franklin, Gasconade, Jefferson, Lincoln, St. Charles, St. Louis (County) and Warren
Fifth	**Robert E. Bregant, M.D.** Jefferson City	Audrain, Boone, Callaway, Camden,* Cole, Cooper, Howard, Miller, Moniteau, Montgomery, Morgan and Osage*
Sixth	**William D. Bradshaw, M.D.** Clinton	Bates, Benton, Cass, Cedar, Henry, Johnson, Lafayette, Pettis, Ray, St. Clair, Saline and Vernon
Seventh	**Andrew McCanse, M.D.** Kansas City	Jackson
Eighth	**Howard J. McAlhany, M.D.** (Vice-Chairman) Springfield	Barry, Barton, Christian, Dade, Dallas, Greene, Hickory, Jasper, Lawrence, McDonald, Newton, Polk, Stone, Taney and Webster
Ninth	**Claude W. Cooper, M.D.** Thayer	Carter, Crawford, Dent, Douglas, Howell, Laclede, Maries, Oregon, Ozark, Phelps, Pulaski, Shannon, Texas and Wright
Tenth	**Eugene T. Hansbrough, M.D.** Poplar Bluff	Bollinger, Butler, Cape Girardeau, Dunklin, Iron, Madison, Mississippi, New Madrid, Pemiscot, Perry, Reynolds, Ripley, St. Francois, Ste. Genevieve, Scott, Stoddard, Washington and Wayne

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* Counties with no medical organization.

Component Societies in Affiliation With the Missouri State Medical Association

County	District	President	Address	Secretary	Address
Andrew	1	Gilbert B. Kelley	Savannah	Warren C. Baker	Savannah
Audrain	5	Leonard L. Davis	Mexico	Thomas L. Dwyer	Mexico
Barton	8	Alvin R. Cain	Lamar	Thomas W. Carroll	Lamar
Boone	5	William C. Allen	Columbia	Elizabeth James	Columbia
Buchanan	1	Randal W. Weed	St. Joseph	John T. Rogers	St. Joseph
Butler-Wayne-Ripley	10	Ricardo Ramirez	Poplar Bluff	D. K. Varma	Poplar Bluff
Callaway	5	Vernon Jackson	Fulton	George Groce	Fulton
Cape Girardeau	10	Jean A. Chapman	Cape Girardeau	Carl F. Ritter	Cape Girardeau
Chariton-Macon-Monroe-Randolph	2	James Campbell	Macon	Robert Tompson	Moberly
Clay	1	Felix A. Pileggi	North Kansas City	Howard Adams	Liberty
Clinton	1	Wilber B. Spalding	Plattsburg	James H. Sweiger	Plattsburg
Cole	5	Kenneth K. C. Siu	Jefferson City	Harold Kanagawa	Jefferson City
Cooper	5	Byron M. Stuart	Boonville	E. T. Humphreys	Boonville
Dallas-Hickory-Polk-Dade	8	Doyle C. McCraw	Bolivar	Lee McNeel	Greenfield
Dunklin	10	Romeo Inarda Santos	Kennett	Quinton Tarver	Kennett
Franklin-Gasconade-Warren	4	Thomas J. Mitchell	St. Clair	Charles H. Sincox	Washington
Grand River Medical Society (Caldwell-Carroll-Livingston-Grundy-Daviess-Harrison-Linn-Mercer-DeKalb)	1			George Mandler	Chillicothe
Greene	8	Walter A. German	Springfield	Donald H. Beisner	Springfield
Henry	6	J. O. Smith	Clinton	Ray S. Hollingsworth	Clinton
Howard	5	William G. Marshall	Glasgow	M. P. Leach	Fayette
Jackson	7	Fred D. Fowler	Kansas City	T. J. Bryant	Kansas City
Jasper	8	Victor M. Carnes	Joplin	M. A. S. Hallaba	Joplin
Jefferson	4	Roger Allbee	Crystal City	Vicente D. Deles	Crystal City
Johnson	6			Jerry Ragland	Warrensburg
Lafayette-Ray	6	Wayne Bodyston	Odessa	K. E. Koppenbrink	Higginsville
Lewis-Clark-Scotland	2			Landis Y. Davis	Canton
Marion-Ralls-Shelby	2	Dale F. Burton	Hannibal	Francis Burns	Hannibal
Mid-Missouri County Medical Society (Phelps-Crawford-Dent-Pulaski-Maries-Laclede)	9	Barbara Russell	Rolla	Bernard Draper	Rolla
Miller	5	Edward O. Shelton	Eldon	Carl T. Buehler, Jr.	Eldon
Mineral Area Medical Society (St. Francois-Iron-Madison-Washington-Reynolds-Bollinger)	10	Norma D. Farmer	Farmington	William Chastain	Farmington
Moniteau	5	Kenyon Latham	California	L. M. Gallagher	California
Montgomery	5			S. J. Byland	Wellsville
Morgan	5	Ruth Kauffman	Versailles	C. Robert Hall	Versailles
North Central Counties Medical Society (Adair-Schuyler-Knox-Sullivan-Putnam)	2	Francis Tarvydas	Edina	Milton T. English	Kirksville
Northwest Missouri Medical Society (Nodaway-Holt-Atchison-Gentry-Worth)	1	Edward Bare	Tarkio	Frank Matteson	Grant City
Ozarks Medical Society (Barry-Lawrence-Stone-Christian-Taney-Newton-McDonald)	8	Charles S. Christianson	Mount Vernon	W. H. Hamilton	Aurora
Pemiscot	10			C. W. McKaskle	Caruthersville
Perry-Ste. Genevieve	10	Alfred E. McDermott	Perryville	Martin L. Key	Ste. Genevieve
Pettis	6	Alvin L. Lowe	Sedalia	William R. Cole	Smithton
Pike	2	Glenn E. Miles	Louisiana	Mathew L. Nickels	Louisiana
Platte	1	Paul C. Vescovo	Kansas City		
St. Charles-Lincoln	4	Roy A. Westerfeld	St. Charles	James Carpenter	St. Charles
St. Louis Medical Society	3	Richard V. Bradley	St. Louis	Carol F. Williams	St. Louis
St. Louis County Medical Society	4	Frederick D. Peterson	St. Louis	Jules H. Kopp	St. Louis
Saline	6	E. Lee McCorkle	Marshall	Richard Raynor	Marshall
SEMO County Medical Society (Stoddard-New Madrid-Mississippi-Scott)	10	Robert C. Ahlvin	Sikeston	Fred Thornton	Sikeston
South Central (Howell-Oregon-Texas-Wright-Douglas-Ozark)	9	Ambrose T. Walker	Thayer	W. T. Morgan, Jr.	West Plains
Webster	8	T. M. Macdonnell	Marshfield	Robert J. Bareis	Marshfield
West Central Missouri Medical Society (Bates-Cass-Cedar-St. Clair-Vernon)	6	Nelson Greenlund	Nevada	R. John Torontow	Nevada

Guide to County Medical Societies

Following is a list of Missouri communities in which MSMA member-physicians are in active practice or reside. Name of the community is followed by the county in which it is located and the medical society to which physicians of that community normally would belong.

A

Town	County	Medical Society
Advance	Stoddard	SEMO
Affton	St. Louis*	
Albany	Gentry	Northwest Missouri
Altenburg	Perry	Perry-Ste. Genevieve
Appleton City	St. Clair	West Central
Arnold	Jefferson	Jefferson
Aurora	Lawrence	Ozarks
Ava	Douglas	South Central

B

Town	County	Medical Society
Ballwin	St. Louis*	
Belton	Cass	West Central
Berkeley	St. Louis*	
Bethany	Harrison	Grand River
Bloomfield	Stoddard	SEMO
Blue Springs	Jackson	Jackson
Bolivar	Polk	Dallas-Hickory-Polk-Dade
Bonne Terre	St. Francois	Mineral Area
Boonville	Cooper	Cooper
Bourbon	Crawford	Mid-Missouri
Bowling Green	Pike	Pike
Branson	Taney	Ozarks
Braymer	Caldwell	Grand River
Brentwood	St. Louis*	
Bridgeton	St. Louis*	
Brookfield	Linn	Grand River
Browning	Linn	Grand River
Brunswick	Chariton	Chariton-Macon-Monroe-Randolph
Buckner	Jackson	Jackson
Buffalo	Dallas	Dallas-Hickory-Polk-Dade
Butler	Bates	West Central

C

Town	County	Medical Society
Cabool	Texas	South Central
Cainesville	Harrison	Grand River
California	Moniteau	Moniteau
Camdenton	Camden	Camden
Cameron	Clinton	Clinton
Cape Girardeau	Cape Girardeau	Cape Girardeau
Cardwell	Dunklin	Dunklin
Carrollton	Carroll	Grand River
Carthage	Jasper	Jasper
Caruthersville	Pemiscot	Pemiscot
Cassville	Barry	Ozarks
Centralia	Boone	Boone
Charleston	Mississippi	SEMO
Chesterfield	St. Louis*	
Chillicothe	Livingston	Grand River
Clarksville	Pike	Pike
Clayton	St. Louis*	
Clinton	Henry	Henry
Columbia	Boone	Boone
Concordia	Lafayette	Lafayette-Ray
Crane	Stone	Ozarks
Creve Coeur	St. Louis*	
Crystal City	Jefferson	Jefferson
Cuba	Crawford	Mid-Missouri

D

Town	County	Medical Society
Desloge	St. Francois	Mineral Area
DeSoto	Jefferson	Jefferson
Dexter	Stoddard	SEMO
Doniphan	Ripley	Butler-Wayne-Ripley

E

Town	County	Medical Society
East Prairie	Mississippi	SEMO
Edina	Knox	North Central
Eldon	Miller	Miller
El Dorado Springs	Cedar	West Central
Elsberry	Lincoln	St. Charles-Lincoln
Everton	Jackson	Jackson
Excelsior Springs	Clay	Clay

F

Town	County	Medical Society
Farmington	St. Francois	Mineral Area
Fayette	Howard	Howard
Fenton	St. Louis*	
Ferguson	St. Louis*	
Festus	Jefferson	Jefferson
Flat River	St. Francois	Mineral Area
Florissant	St. Louis*	
Forsyth	Taney	Ozarks
Fort Leonard Wood	Pulaski	Mid-Missouri
Fredericktown	Madison	Mineral Area
Frontenac	St. Louis*	
Fulton	Callaway	Callaway

G

Town	County	Medical Society
Gallatin	Daviess	Grand River
Gashland	Clay	Clay
Gerald	Franklin	Franklin-Gasconade-Warren
Gideon	New Madrid	SEMO
Gladden	St. Louis*	
Glasgow	Howard	Howard
Glendale	St. Louis*	
Grandview	Jackson	Jackson
Grant City	Worth	Northwest Missouri
Gravois Mills	Morgan	Morgan
Greenfield	Dade	Barton-Dade

H

Town	County	Medical Society
Hamilton	Caldwell	Grand River
Hannibal	Marion	Marion-Ralls-Shelby
Harrisonville	Cass	West Central
Hayti	Pemiscot	Pemiscot
Herculaneum	Jefferson	Jefferson
Hermann	Gasconade	Franklin-Gasconade-Warren
Hickman Mills	Jackson	Jackson
Higginsville	Lafayette	Lafayette-Ray
Hillsboro	Jefferson	Jefferson
Hornersville	Dunklin	Dunklin
Houston	Texas	South Central
Humansville	Polk	Dallas-Hickory-Polk-Dade
Huntsville	Randolph	Chariton-Macon-Monroe-Randolph

I

Town	County	Medical Society
Illmo	Cape Girardeau	Cape Girardeau
Independence	Jackson	Jackson
Ironton	Iron	Mineral Area

J

Town	County	Medical Society
Jackson	Cape Girardeau	Cape Girardeau
Jefferson Barracks	St. Louis*	
Jefferson City	Cole	Cole
Jennings	St. Louis*	
Joplin	Jasper	Jasper

K

Town	County	Medical Society
Kansas City	Jackson	Jackson
Kennett	Dunklin	Dunklin
King City	Gentry	Northwest Missouri
Kirksville	Adair	North Central
Kirkwood	St. Louis*	
Knobnoster	Johnson	Johnson
Knox City	Knox	North Central
Koch	St. Louis*	

L

Town	County	Medical Society
Ladue	St. Louis*	
Lamar	Barton	Barton
Lawson	Ray	Lafayette-Ray
Leawood (Kan.)		Jackson
Leadwood	St. Francois	Mineral Area

*** Member may belong to St. Louis County Medical Society or St. Louis Medical Society.**

Town	*County*	*Medical Society*
Lebanon	Laclede	Mid-Missouri
Lee's Summit	Jackson	Jackson
Lemay	St. Louis*	
Lexington	Lafayette	Lafayette-Ray
Liberty	Clay	Clay
Lockwood	Dade	Dallas-Hickory-Polk-Dade
Louisiana	Pike	Pike
M		
Macon	Macon	Chariton-Macon-Monroe-Randolph
Malden	Dunklin	Dunklin
Maplewood	St. Louis*	
Marceline	Linn	Grand River
Marshall	Saline	Saline
Marshfield	Webster	Webster
Martin City	Jackson	Jackson
Maryville	Nodaway	Northwest Missouri
Memphis	Scotland	Lewis-Clark-Scotland
Mexico	Audrain	Audrain
Milan	Sullivan	North Central
Moberly	Randolph	Chariton-Macon-Monroe-Randolph
Monett	Barry	Ozarks
Montgomery City	Montgomery	Montgomery
Morehouse	New Madrid	SEMO
Mound City	Holt	Northwest Missouri
Mountain Grove	Wright	South Central
Mountain View	Howell	South Central
Mount Vernon	Lawrence	Ozarks
N		
Neosho	Newton	Ozarks
Nevada	Vernon	West Central
New Florence	Montgomery	Montgomery
New Haven	Franklin	Franklin-Gasconade-Warren
New Madrid	New Madrid	SEMO
Normandy	St. Louis*	
North Kansas City	Clay	Clay
O		
Oak Grove	Jackson	Jackson
Odessa	Lafayette	Lafayette-Ray
O'Fallon	St. Charles	St. Charles-Lincoln
Olivette	St. Louis*	
Osceola	St. Clair	West Central
Overland	St. Louis*	
Owensville	Gasconade	Franklin-Gasconade-Warren
Ozark	Christian	Ozarks
P		
Pacific	Franklin	Franklin-Gasconade-Warren
Palmyra	Marion	Marion-Ralls-Shelby
Paris	Monroe	Chariton-Macon-Monroe-Randolph
Parkville	Platte	Platte
Parma	New Madrid	SEMO
Pattonsburg	Daviess	Grand River
Pattonville	St. Louis*	
Perryville	Perry	Perry-Ste. Genevieve
Piedmont	Wayne	Butler-Wayne-Ripley
Pine Lawn	St. Louis*	
Platte City	Platte	Platte
Plattsburg	Clinton	Clinton
Pleasant Hill	Cass	West Central
Poplar Bluff	Butler	Butler-Wayne-Ripley
Portageville	New Madrid	SEMO
Potosi	Washington	Mineral Area
Prairie Village (Kan.)		Jackson
Princeton	Mercer	Grand River
R		
Raytown	Jackson	Jackson
Reeds Spring	Stone	Ozarks
Republic	Greene	Greene
Rich Hill	Bates	West Central
Richmond	Ray	Lafayette-Ray
Richmond Heights	St. Louis*	
Rivermines	St. Francois	Mineral Area
Robertson	St. Louis*	
Rock Hill	St. Louis*	
Rockport	Atchison	Northwest Missouri
Rolla	Phelps	Mid-Missouri
S		
St. Ann	St. Louis*	
St. Charles	St. Charles	St. Charles-Lincoln
St. Clair	Franklin	Franklin-Gasconade-Warren
Ste. Genevieve	Ste. Genevieve	Perry-Ste. Genevieve
St. James	Phelps	Mid-Missouri
St. Joseph	Buchanan	Buchanan
St. Louis City*		
Salem	Dent	Mid-Missouri
Salisbury	Chariton	Chariton-Marion-Monroe-Randolph
Sappington	St. Louis*	
Sarcoxie	Jasper	Jasper
Savannah	Andrew	Andrew
Sedalia	Pettis	Pettis
Shawnee Mission (Kan.)		Jackson
Shelbina	Shelby	Marion-Ralls-Shelby
Shelbyville	Shelby	Marion-Ralls-Shelby
Shrewbury	St. Louis*	
Sikeston	Scott	SEMO
Slater	Saline	Saline
Smithton	Pettis	Pettis
Smithville	Clay	Clay
Springfield	Greene	Greene
Stanberry	Gentry	Northwest Missouri
Steele	Pemiscot	Pemiscot
Steelville	Crawford	Mid-Missouri
Stockton	Cedar	West Central
Strafford	Greene	Greene
Sullivan	Franklin	Franklin-Gasconade-Warren
Sweet Springs	Saline	Saline
T		
Tarkio	Atchison	Northwest Missouri
Thayer	Oregon	South Central
Trenton	Grundy	Grand River
Troy	Lincoln	St. Charles-Lincoln
U		
Union	Franklin	Franklin-Gasconade-Warren
University City	St. Louis*	
V		
Valley Park	St. Louis*	
Vandalia	Audrain	Audrain
Versailles	Morgan	Morgan
W		
Warrensburg	Johnson	Johnson
Warrenton	Warren	Franklin-Gasconade-Warren
Warsaw	Benton	Benton
Washington	Franklin	Franklin-Gasconade-Warren
Waverly	Lafayette	Lafayette-Ray
Waynesville	Pulaski	Mid-Missouri
Webb City	Jasper	Jasper
Webster Groves	St. Louis*	
Wellsville	Montgomery	Montgomery
Wentzville	St. Charles	St. Charles-Lincoln
West Plains	Howell	South Central
Willard	Greene	Greene
Willow Springs	Howell	South Central
Windsor	Henry	Henry
Winona	Shannon	Carter-Shannon
Winston	Daviess	Grand River

*** Member may belong to St. Louis County Medical Society or St. Louis Medical Society.**

Alphabetical Roster of Members

(See Instructions on Page 405)

A

Aaron, George A., Independence
Abaqueta, Gamaliel P., Kansas City
Abel, Charles C., St. Louis
Abel, Oliver, III, St. Louis
Abele, Wm. A., Boonville
Abelardo, Miguel L., St. Louis
Abell, Walter E., St. Louis
Abella, Bienvenido Z., Kansas City
Abercrombie, Keith J., Kansas City
Abinoja, Conrado B., St. Louis
Abrams, Bernard M., Kansas City
Abrams, Morris, St. Louis
Abramson, Charles L., St. Louis
Acker, Harry L., St. Louis
Ackerman, Lauren V., St. Louis
*Ackley, Edward J., Kansas City
Acuff, R. Phillip, St. Joseph
Adair, Richard, Kansas City (Member Clay County Medical Society)
Adams, Harold D., Columbia
Adams, Howard D., Liberty
Adams, Robert B., Jr., Joplin
Adelman, Arthur, Kansas City
Adeyemi-Doro, Henry, St. Louis
Adler, Benard C., St. Louis
Adler, Federico, Kansas City
Agasino, Armela R., St. Louis
Agasino, Gaudencio, Sullivan (Member St. Louis Medical Society)
Agee, Loren G., Kansas City
Agress, Harry, St. Louis
Aguinaldo, Jaime A.. St. Louis
Ahad, Abdul, St. Joseph
Ahadi, Abd Ul Ahad, St. Louis
Ahern, Archibald M., St. Louis
Ahlering, George H., St. Louis
Ahlvin, Robert C., Sikeston
Ahmad, Bashir, St. Louis
Ahuja, A. L., St. Louis
Aitken, Louis F., St. Louis
Ajano, Z. A., Mexico
Aker, Umit, St. Louis
Aks, Daniel, Kansas City
Akyol, Salim, St. Louis
Albano, Benjamin I., Crystal City
Albera, Victor H., St. Louis
Alberg, Marvin R., Kansas City
Alderman, Thomas F., Kansas City
Alegre, Jorge M., St. Louis
Aleksander, Bernardo, St. Louis
Alex, Morris, St. Louis
Alexander, France, St. Louis
Alexander, Frazier D., St. Louis
Alexander, George K., Ballwin
Alisuag, Andres, Jr., St. Charles
Allain, James J., North Kansas City
Allan, James E., Jefferson City
Allan, James R., Liberty
Allbee, Roger H., Crystal City
Allebach, Hobart K., Kansas City
Allen, Claude J., Rich Hill
Allen, David O., Joplin
Allen, E. Warren, Carrollton
Allen, Henry C., Clayton
Allen, Hollis N., St. Louis
Allen, James H., St. Louis
Allen, Jerry H., Springfield
Allen, Joseph E., Columbia
Allen, Louis A., N. Kansas City
Allen, Melvin A., St. Louis
Allen, Robert E., Kansas City
Allen, Robert W., Columbia
Allen, S. Lloyd, Kansas City
Allen, Willard M., Baltimore, Md. (Member St. Louis Medical Society)
Allen, William C., Columbia
Allen, William E., Jr., St. Louis
Allen, William H., Nevada
Allison, James B., Springfield
Almiron, Osias A., St. Louis
Almond, Carl H., Columbia
Alonso, Jose Mario V., Jr., St. Louis
Alonso, William A., St. Louis
Alonso-Yague, P., St. Louis
Alsop, Webb S., Jr., Kansas City
Althaus, Carl Jacob, Ballwin
Altheide, Harvey E., Ladue
Altheide, J. Paul, St. Louis
Altman, Marvin P., St. Charles
Altomare, Edward P., Kansas City
Alvarez, Luis L., St. Louis
Alvarez, Ulises C., St. Louis
Alvis, Bennett Y., St. Louis
Alvis, Edmund B., St. Louis
Alyea, J. O., Cape Girardeau
Amado-Ledo, David E., St. Louis
Ames, Mary B., Kansas City
Ames, William H., St. Joseph
Amin, Avora M., St. Louis
Amin, Navinkumar J., St. Louis
Amjad, Mohammad T., Ballwin
Ammatelli, Francis J., Kansas City
Amoury, Raymond A., Kansas City
Ancheta, Apolinario A., Springfield
Anderson, Charles B., St. Louis
Anderson, Ivan A., Columbia
Anderson, John M., St. Louis
Anderson, Paul B., Neosho
Anderson, Philip C., Columbia
Anderson, Raymond B., Kansas City
Anderson, Richard W., Kansas City
Anderson, Thomas R., Columbia
Andreassen, Dimil F., Rolla
Andres, Edward H., St. Joseph
Andrews, Berneil W., N. Kansas City (Member Clay County Medical Society)
Andrus, Bailey C., Kansas City
Angelillo, John C., Florissant
Anglo, Luis B., St. Louis
Ansari, Ansar H., St. Louis
Anslinger, David I., St. Louis
Anstey, George, St. Ann
Anthony, Dallas, Springfield
Anthony, Elwyn J., St. Louis
Antoniou, Christos, St. Ann
Apostol, Andres G., Monett
Appleberry, Charles H., Rivermines
Aquino, Philip J., Caruthersville
Arana, Victor A., Fulton
Arat, Metin, Farmington
Arbab, Ali A., Kansas City
Arenberg, Irving K., St. Louis
Arenos, Proceso T., Jr., St. Louis
Arias, Fernando, St. Louis
Arms, Arnold V., Kansas City
Armstrong, Jay H., Shawnee Mission, Kan. (Member Clay County Medical Society)
Armstrong, John W., St. Louis
Arneson, Axel N., St. Louis
Arney, William G., St. Louis
Arnold, Eugene L., St. Louis
Arnold, Herbert M., Lamar
Arnold, John D., Kansas City
Arnold, Kenneth J., St. Louis
Arnold, Richard C., Columbia
Aronson, Abraham, St. Louis
Arnot, John P., St. Louis
Arribas, Neva P., St. Louis
Arribas, Romeo F., Blue Springs
Arst, Herbert E., Kansas City (Member Clay County Medical Society)
Aschman, Theodore H., Kansas City
Asel, Norman D., Columbia
Ash, Charles J., Springfield
Ashby, Jennifer D., Kansas City
Ashcraft, Keith W., Kansas City
Asher, A. Graham, Kansas City
Ashley, Hugh V., Cape Girardeau
Ashley, John T., Kansas City
Ashley, Thomas F., Springfield
Asnani, Mithlesh G., Kansas City
Atcheson, Windsor B., Trenton
Atkinson, Thomas E., Jr., Springfield
Atwell, Floyd C., Kansas City
Auer, Arthur I., St. Louis
Auer, Edward T., St. Louis
Aufderheide, G. Russell, St. Louis
Auguste, Jean Meledain, St. Louis
Augustin, Cesar, St. Louis
Augustine, Robert W., Southfield, Mich. (Member Buchanan County Medical Society)
Aulenbacher, Carl E., Washington
Auner, Cecil R., Springfield
Averill, Keith H., Kansas City
Avery, Willard B., Boonville
Avila, Estrella Z., Manchester
Avila, Patricio C., Manchester
Avioli, Louis V., St. Louis
Ayata, Sedat M., St. Louis
Aykent, Yavuz, St. Louis
Aylward, Howard J., St. Louis
Ayotte, Nancy C., Kansas City
Ayvazian, Vatche H., St. Louis
Azuma, Nobutaka, St. Louis
Azzouni, J. N., High Ridge

B

Babka, Joseph J., St. Louis
Bach, Lysle M., Hannibal
Back, Donald K. Springfield
Backer, Matthias H., Jr., St. Louis
Badger, Virginia M., St. Louis
Baer, Alvin J., Kansas City
Bagby, James W., Clayton
Bagwe, Lata R., St. Louis
Bahn, Charles F., Cape Girardeau
Bai, Sangzin, Festus
Baik, Kil Young, Waverly
Bailey, Alan H., Springfield
Bailey, Drennan, St. Louis
Bailey, William H., St. Louis
Baird, Keim L., St. Louis
Baker, A. Sherwood, Columbia
Baker, Donald L., Union
Baker, James M., Columbia
Baker, Josephine D., Moberly
Baker, Philip J., Kansas City
Baker, Warren C., Savannah
Balanoff, Arnold Z., Kansas City
Baldwin, Richard, Springfield
Baldwin, Theodore R., Excelsior Springs
Bales, Eugene L., Carrollton
Balhuizen, John, Kansas City
Ballard, V. Bryce, Kansas City
Ballinger, Walter F., II, St. Louis
Balster, Vernon H., St. Louis
Bamshad, Jerry, Hazelwood
Bandle, Donald F., St. Louis
Banet, Samuel R., St. Louis
Banjastikul, Chusak, St. Louis
Bankuti, Ferenc, Kansas City
Banton, M. Roman, St. Louis
Banton, Thomas J., St. Louis
Banton, William C., St. Louis
Barbee, Charles W., Columbia
Barbour, Marvin R., Poplar Bluff
Bardsley, John L., St. Louis
Bare, Chester I., Jr., Kansas City
Bare, Edward F., Tarkio
Bareis, Robert J., Marshfield
Barelli, Pat A., Kansas City
Barker, Edward T., St. Louis
Barloon, James H., Kansas City
Barnard, John L., Jr., Kansas City
Barner, Hendrick, St. Louis
Barnes, Seth S., Cape Girardeau
Barnett, Charles H., Bolivar
Barnett, Floyd A., Paris
Barnett, Gordon P., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Barnhill, Floyd R., Springfield
Barone, Paul L., Nevada
Barr, Glenn A., Kansas City
Barragan, Hector, Ballwin
Barrett, Scott R., St. Louis
Barrow, Jack, St. Louis
Barry, Gerald W., Kansas City
Barry, William B., Kansas City
Bartlett, Robert W., St. Louis
Bartlett, Willard, Jr., St. Louis
Bartnick, Mitchel L., De Soto
Bartulica, Nicholas, St. Joseph
Basantz, Fernando V., Kansas City
Baska, R. E., Kansas City
Bass, Billy J., Salem
Bass, Lewis N., Kansas City
Bass, Walter R., Kansas City
Bates, George C., N. Kansas City (Member Clay County Medical Society)
Baue, Arthur E., St. Louis
Bauer, Harold A., Springfield (Member Dallas-Hickory-Polk-Dade County Medical Society)
Bauer, John D., St. Louis
Bauer, Joseph A., St. Louis
Bauer, Lafe W., Kansas City
Bauer, Maria, Granite City, Ill. (Member St. Louis Medical Society)
Bauer, Otto, Granite City, Ill. (Member St. Louis Medical Society)
Bauer, Robert A., St. Louis
Baula, Armindo G., St. Louis
Baum, Frank E., Kansas City
Bauman, Henry C., Maryville
Baumann, A. R., Steelville
Baumgarten, Walter, Jr., St. Louis
Bauschard, Frederick, St. Louis
Bautista, Rogelio L., Moberly (Member St. Charles-Lincoln County Medical Society)
Bay, Merrill R., Blue Springs
Bayer, William L., Kansas City
Bayrakdar, Admad K., St. Louis
Bealer, Louis A., Lebanon

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* Doctor of Osteopathy.

Beard, R. Wheatley, North Little Rock, Ark. (Member Greene County Medical Society)
Beard, William J., Lee's Summit
Beare, J. Byron, St. Louis
Beasley, L. Kenneth, St. Louis
Beato, David L., St. Louis
Beatty, Arch J., Kansas City
Beatty, Eugene C.. Kansas City
Beatty, Nina D., Kansas City
Beaty, William R., St. Louis
Beck, Calvin E., Kansas City
Beck, Paul M., St. Joseph
Becker, Bernard, St. Louis
Becker, Edward J., St. Louis
Becker, George H., St. Louis
Becker, Richard R., Kansas City
Becker, Rolfe A., Kansas City
Becker, Stanley C., St. Louis
Beckette, Edmund S., St. Louis
Beckloff, Gerald L., Kansas City
Beckman, Donald E., St. Louis
Beecher, Sheldon B., Poplar Bluff
Beeks, John W., Kansas City (Member Clay County Medical Society)
Beheler. Edward M., St. Joseph
Behrends. Steven H., Kansas City
Behrens, Donald T., St. Louis
Behrens, Gerald L., St. Louis
Beidle, Raymond J., St. Ann
Beisner, Donald H., Springfield
Belancourt, Dunet F., St. Louis
Belden. Edgar A., Jefferson City
Belew, Joe E., St. Louis
Bell, Hubert H., Kansas City
Bell, Robert M., Hannibal (Member St. Louis Medical Society)
Bell, William F., Lee's Summit
Benage, Clarence M., Florissant
Bennett, James D.. Kansas City
Bennett, Kenneth J., St. Louis
Benoit, Hector Wright, Jr., Kansas City
Benson, John F., St. Louis
Benson, Leo J., Jr., Kennett
Benson, Ronald G., Springfield
Benson, Scott C., St. Joseph
Benson, William F., Kansas City
Bentlage, Charles H., Joplin
Bentley, John D., Springfield
Berard, Louis N., St. Louis
Berenson, Sheldon E., Kansas City
Berg, Edward F., Ladue
Berg, Leonard, St. Louis
Berg, Ralph, St. Louis
Berger, Edward J., St. Louis
Bergman, Hugo F., St. Louis
Bergmann, Dwayne, St. Louis
Bergmann, John F., St. Louis
Bergmann, Martin, St. Louis
Bergmann, Victor H., Kansas City
Bergner, Grace E., St. Louis
Berland. Harry I., St. Louis
Berlin, Roger, Kansas City
Berman, William, St. Louis
Bernabe, Florinio H., Manchester
Bernabe, Ofelia M., Manchester
Bernard, J. W., Caruthersville
Berndsen, Gerard H., Rock Hill
Berney, Francis J., St. Joseph
Berni, Anthony A.. St. Louis
Bernreiter, Michael, Kansas City
Bernstein, Aaron M., Clayton
Berry, John W., St. Louis
Berry, Maxwell G., Kansas City
Berry, Paul T., Springfield
Bersche, Bertram L., St. Louis
Berwald, David M., Bridgeton
Berwald, Irwin I., St. Louis
Best, Robert, Overland Park, Kan. (Member Lafayette-Ray County Medical Society)
Bettonville, Paul J., Jr., St. Louis
Betz, Richard J., Neosho
Betz, Robert F., Neosho
Bhend, David P., Joplin
Bickel, Vern T., Lamar
Bickley, James E., Kansas City
Biddy, Ralph L., St. Louis
Bidwell, Robert E. G., Kansas City
Biggs, Alfred D., Jr., Kansas City
Biggs, Fred J., Jr., Poplar Bluff
Biggs, Harry L., Kansas City
Bikales, Victor W., Kansas City
Bills, Marvin L., Kansas City
Bilsky, Nathan, St. Louis
Bindbeutel, Donald A., St. Louis
Binder, Morton A., St. Louis
Bircher, John L., St. Louis
Bird, H. Waldo, St. Louis
Birenbaum, Aaron, St. Louis
Birge, Clifford A., St. Louis
Birsner, Frank H., Carthage
Bishop, Marion D., Florissant
Bishop, Mary M., St. Louis
Bisno, Daniel, St. Louis
Black, Don A., Kansas City
Black, Eugene C., Kansas City
Black, Samuel P. W., Columbia
Black, Thomas C., Jr., Kansas City
Blackman, Nathan, Kirkwood
Blackmore, Thomas A., Windsor
Blackwell, Charles R., Maryland Heights
Blackwell, Charles W., Columbia
Blades, Ross D., Springfield
Bladow, Terrence C., Joplin
Blair, Vilray P., Jr., St. Louis
Blalock, Robert W., Marshall
Blank, Michael K., San Antonio, Tex. (Member Jefferson County Medical Society)
Blankenship, Dale M., Cape Girardeau
Blankenship, George W., Neosho
Blanton, J. C., Sikeston
Bleisch, Virgil R., St. Louis
Blim, Richard D., Kansas City
Bliss, Joy V., Excelsior Springs
Block, Arnold S., St. Louis
Block, J. E., Sedalia
Blount, Lee, Jr., St. Louis
Boc, Inocencio M., St. Louis
Bockelman, Clifford H., Brentwood
Boedeker, Roy V., St. Louis
Boemer, Lilburn C., St. Louis
Boger, James W., Sedalia
Bohigian, George, St. Louis
Bohnsack, Ralph W., Brookfield
Bolch, Oscar H., Jr., Pasadena, Calif. (Member St. Louis Medical Society)
Boldizar, Albert G., St. Louis
Boldt, Thomas H., St. Louis
Boles, C. Read, Clayton
Bolinske, Robert E., St. Louis
Bollozos, George D., St. Louis
Bolton, Robert L., Ballwin
Bond, Leslie F., St. Louis
Bondurant, Bryce H., St. Louis
Bonebrake, M. D., Springfield
Bonfanti, Albert L., St. Louis
Bonifacio, Andres S., Crystal City
Boniuk, Isaac, St. Louis
Bonney, Samuel C., Washington
Boone, Daniel C., Kansas City
Boone, Martin H., Jr., Springfield
Boonkham, C., St. Louis
Boonshaft, Benje, St. Louis
Bopp, Jon Ronald, Joplin
Bordy, Marvin D., Kansas City
Borenstine, Joseph, Kansas City
Borja, Egbert, Springfield
Borowsky, Benjamin A., St. Louis
Borromeo. Carlos J., Rivermines
Borsuk, Gregory M., Kansas City
Bortnick, Arthur R., St. Louis
Bortnick, Eugene, Kansas City
Botwin, Arnold E., Kansas City
Bourgeois, Curtis, Columbia
Bourke, Thomas E., St. Louis
Boutros, Amin, Kansas City
Boveri, Joseph C., St. Louis
Bowdern, Edward H., Richmond Heights
Bowe, Edwin Earl, Jefferson City
Bowen, Stephen F., Jr., St. Louis
Bowerman, Harold H., St. Louis
Bowers, James E., Kirkwood
Bowersox, Warren A., Pacific
Bowles, G. Robert, St. Louis
Bowles, Richard P., Liberty
Bowles, William T., St. Louis
Bowman, Melvin C., Neosho
Bowman, William K., Cape Girardeau
Bowser, John F., Kansas City
Boyarsky, Saul, St. Louis
Boyce, John Milton, Mexico
Boyd, Arthur M., St. Louis
Boyd, George K., Kansas City
Boydston, Catherine, Odessa
Boydston, W. Wayne, Odessa
Boyer, Philip A., Jr., Kansas City
Boylan, Peter C., Kansas City
Bozzo, Raymond J., Washington
Braby, Howard H., Independence
Bradford, John F., Kansas City
Bradley, Richard V., Clayton
Bradley, William B., Jefferson City
Bradley, William W., Centralia
Bradshaw, W. D., Clinton
Brady, Arthur M., Kansas City
Brady, Harry R., St. Louis
Brady, Hugh S., Concordia
Brams, Jack B., Kansas City
Brand, Earl L., Webster Groves
Brandon, Frederick M., Joplin
Brangle, Robert W., St. Louis
Brasher, Ben H., Lexington
Braufman, Harvey S., St. Louis
Braverman, Abe E., Kansas City
Braverman, Elliot M., Sedalia
Brazos, John C., Smithton
Bregant, Robert E., Jefferson City
Bremer, Rita, St. Louis
Bremser, Harry L., St. Louis
Brennan, Daniel J., St. Louis
Brennan, George A., St. Louis
Brennan, Patricia A., St. Louis
Brennan, Raymond J., Chillicothe
Brennan, Robert A., St. Louis
Brennan, Robert V., St. Louis
Brenner, Paul A., Owensville
Brent, Lanny R., Springfield
Brereton, Robert L., Kirkwood
Bricker, Eugene M., St. Louis
Brion, Pacelli E., St. Louis
Briscoe, John R., St. Louis
Bristow. Robert B., St. Joseph
Brizio-Molteni, Loredana, N. Kansas City
Broaddus, Loren, Springfield
Brodeur, Armand E., St. Louis
Bronson, Shael S., St. Louis
Brookes, Robert D., St. Louis
Brookreson, Alton D., Poplar Bluff
Brookreson, Alton F., Poplar Bluff
Brooks, John E., St. Louis
Brother, George M., St. Petersburg, Fla. (Member St. Louis County Medical Society)
Broun, Goronwy O., St. Louis
Broun, Goronwy O., Jr., St. Louis
Brower, Clyde L., Independence
Brown, Adrian J., Kansas City
Brown, Daniel W., San Diego, Calif. (Member St. Louis Medical Society)
Brown, David W., Springfield
Brown, E. Eugene, St. Louis
Brown, Elwyn S., Kansas City
Brown, Frederick B., Aurora
Brown, Irwin S., Kansas City
Brown, James L., St. Louis
Brown, James M., St. Louis
Brown, James T., Springfield
Brown, John J., Fulton
Brown, Katherine S., Fulton
Brown, Lyman D., Springfield
Brown, Menzie H., Kansas City
Brown, Robert S., Kansas City
Brown, Seymour, Chesterfield
Brown, Violeta O., Kansas City
Brownsberger, Robert H., Appleton City
Broyles, Watkins A., Bethany
Bruce, Helen L., St. Louis
Bruce, Leo A., Sikeston
Brugger, Thomas, St. Louis
Brukardt, Diane, Columbia
Brumm, Lawrence W., Kansas City
Bruner, Claude R., Camdenton (Member Boone County Medical Society)
Bruner, Robert E., Kansas City
Bruns, Kenneth, St. Louis
Brust, Carl H., Mission, Kan. (Member Jackson County Medical Society)
Bryan, James H., Clayton
Bryan, William H., Jr., Kansas City
Bryan, William T. K., St. Louis
Bryant, Sydney L., St. Joseph
Bryant, T. J., Kansas City
Buben, Robert W., Hannibal
Buchanan, Barbara N., Kansas City
Buckingham, William, Kansas City
Buckner, Robert C., Kansas City
Bucy, James G., St. Louis
Budd, John J., Jr., St. Louis
Budke, Harold A., Kansas City
Buehler, Carl T., Jr., Eldon
Buhler, Victor B., Kansas City
Buie, Bruce R., Kansas City
Bumgarner, James E., Columbia
Bumgarner, Roger W., Columbia
Bunting, Williston P., Kansas City
Burch, John E., Joplin
Burcham, Tom R., Jr., Farmington
Burde, Ronald M., St. Louis
Burdge, Robert E., St. Louis
Burford, Edwin K., Jr., Cape Girardeau
Burford, Thomas H., St. Louis
Burk, E. K., Kansas City
Burke, Robert J., St. Louis
Burkey, Jordan W., Springfield
Burkhart, Charles A., St. Louis
Burkhart, Edward F., St. Louis
Burmeister, R. William, St. Louis
Burns, Francis J., St. Louis
Burns, Francis R., Hannibal
Burns, Thomas W., Columbia
Burnside, Charles R., Kirkwood
Burr, Donald C., St. Louis
Burry, Virgil F., Kansas City
Burst, Donald O., St. Louis
Burstein, Robert, St. Louis
Burton, Dale F.. Hannibal
Busby, William E., Jefferson City
Busch, Anthony K., St. Louis
Busiek, Erwin F., Springfield

Busiek, Paul J., Springfield
Busiek, Urban J., Springfield
Bussmann, Donald W., St. Louis
Butcher, Harvey R., Jr., St. Louis
Butcher, Robert W., Kansas City
Butler, E. F., St. Joseph
Butler, Patrick L., Diamond
Butsch, Richard H., St. Louis
Butt, James H., Columbia
Butterworth, Nelson S., Kansas City
Butts. James D., Rolla
Byland, Benjamin F., Maryville
Byland, Samuel J., Wellsville
Bynum, William R., Columbia
Byrne, John E., St. Louis
Byrne, Paul A., St. Louis
Byrum, Fritz A., Ballwin

C

Cabal, Edito C., St. Louis
Cabonce, August L., Florissant
Cabral, Galileu, Florissant
Cabrera, Tomas V., O'Fallon
Caciolo, Carlo, St. Louis
Cacioppo, Joseph E., St. Louis
Cadice, John B., Florissant
Caffrey, Raymond J., Kansas City
Cain, Alvin R., Lamar
Cain, Charles F., Caruthersville
Calderon, Marcos, El Paso, Tex. (Member St. Louis Medical Society)
Caldwell, Fred, Poplar Bluff
Caldwell, John K., Kansas City
Callaghan, Gerard M., St. Louis
Callahan, Donald E., Jennings
Callahan, Joseph D., St. Louis
Callaway, Guy D., Springfield
Callaway, Guy D., Jr., Springfield
Callihan, Charles F., West Plains
Callman, George, St. Joseph
Calodney, Martin M., St. Louis
Calovich, Emery R., Kansas City
Camel, H. Marvin, St. Louis
Camp, Richard V., Jr., Poplar Bluff
Campbell, A. J., Sedalia
Campbell, Cecil S., St. Louis
Campbell, Edward D., Cape Girardeau
Campbell, Frederick B., Kansas City
Campbell, James E., Macon
Campbell, James W., Advance
Campbell, John G., Kansas City
Campos, Antonio, St. Louis
Campos, Francisco J., St. Louis
Canaan, Samuel A., Jr., St. Louis
Cancelada, Juan, Farmington
Canlas, Arsenio L., St. Louis
Canlas, Emilio M., Poplar Bluff
Cannon, Edward M., St. Louis
Cantor, Harvey E., St. Louis
Canty, Eugene J., St. Charles
Capetti, Alex P., Crane
Capps, Eugene C., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Carder, George A., Kansas City
Carleton, Charles E.. Jr., Farmington
Carlin, Albert L., Stanberry
Carlin, M. Richard, St. Louis
Carls, Garry L., St. Louis
Carlson, Arne E., St. Louis
Carlson, E. C., Poplar Bluff
Carlson, Gabrielle A., St. Louis
Carlson, Hjalmar E., Kansas City
Carlson, John S., Kansas City
Carmona, Gilberto V., Arnold
Carnahan, Charles E., Columbia
Carnell, B. M., Camdenton
Carnes, Victor M., Joplin
Carpenter, George T., St. Joseph
Carpenter, James L., St. Charles
Carpenter, Wallace, Rockport
Carr, Archie D., St. Louis
Carr, Phillip W., Springfield
Carranza, Mauro J., Hillsboro
Carrera, Mario, St. Louis
Carrier, John A., St. Louis
Carrington, Howard W., Lebanon
Carroll, George A., St. Louis
Carroll, Grayson, St. Louis
Carroll, Percy J., Clayton
Carroll, Richard C., Metairie, La. (Member Jefferson County Medical Society)
Carroll, Thomas W., Lamar
Carron, Joseph F., Arnold
Carron, Oscar A., Perryville
Carson, Richard A., Vista, Calif. (Member St. Louis Medical Society)
Carter, Edwin E., Creve Coeur
Carter, James E., Kansas City
Carter, James R., Neosho
Carter, John F., St. Louis
Caruso, Alfred A., Kansas City

Cary, John M., St. Louis
Case, Mary E. S., St. Louis
Case, William F., Kansas City
Casebolt, Buford T., Grand Forks, N. D. (Member Jackson County Medical Society)
Casey, Edwin J., St. Louis
Casey, Eliot, Florissant
Cash, Charles R., Kennett
Cason, Elbert H., St. Louis
Cassel, Melvin A., St. Louis
Castasus, Manuel, St. Louis
Castillo, Jose L., Sikeston
Castillo, Michael E., Kansas City
Castro, Juan M., Creve Couer
Catalano, J. Denis, Springfield, Va. (Member St. Louis Medical Society)
Catanzaro, Anthony F., St. Louis
Catanzaro, Francis J., St. Louis
Catanzaro, Rudolph E., St. Louis
Cattaneo, Ernest A., Kansas City
Cavanagh, Denis, St. Louis
Cavaness, Ernest W., Encinitas, Calif. (Member Jackson County Medical Society)
Cayabyab, Pedro C., St. Louis
Cejas, Leandro P., Sikeston
Centner, Paul J., Kansas City
Chadaratana, Phadung, St. Louis
Chakrobortty, Hirendra, St. Louis
Chalkley, Judson I., Columbia
Challener, William A., III, St. Joseph
Chambers, James Q., Jr., Kansas City
Chamness, James T., St. Louis
Chand, Suresh, St. Louis
Chandler, R. Allen, Kansas City
Chandra, Mahesh D., Independence
Chang, Shih-Chung, Maplewood
Chaplin, Hugh, Jr., St. Louis
Chapman, Charles L., Columbia
Chapman, David W., Independence
Chapman, James H., Kansas City
Chapman, Jean A., Cape Girardeau
Charles, Benjamin H., St. Louis
Charles, Francois R., St. Louis
Charnas, Raymond M., St. Louis
Chase, Ned B., Jr., Joplin
Chastain, Charles W., Farmington
Chaudhary, Mohammad A., Kansas City
Chaudhuri, Tapan K., Kansas City
Cheek, Charles W., Columbia
Cheek, J. William, Springfield
Chen, Chung-Kuang, St. Louis
Chernoff, Selbert G., Kansas City
Cherre, Anthony J., St. Louis
Cherre, Charles J., St. Louis
Chesanow, Robert L., St. Louis
Chesney, George W., Joplin
Cheuk, Shu-sum, St. Louis
Chiasson, E. Chaille, Columbia
Chieffi, Margaret, St. Louis
Childs, Donnalea S., Kansas City
Childs, Richard M., Kansas City
Chiles, David R.. Smithville
Chinsky, Murray, St. Ann
Chipongian, Raul A., Florissant
Chishti, M. Ishaq, St. Louis
Cho, Kyu S., St. Louis
Choi, Sae Rong, St. Louis
Chou, Yen Ping, Koch
Choudhuri, Ajit Kumar, St. Louis
Chouinard, Michael D., St. Louis
Chowdhury, Dipak, Independence
Christ, Martin H., St. Joseph
Christianson, Charles S., Mt. Vernon
Christy, John P., Poplar Bluff
Christy, Raymond A., Springfield
Chua, Steven H. T., Florissant
Chung, Kap Eun, St. Louis
Chung, Richard T., Kansas City
Chute, W. Deward, Moberly
Ciapciak, Stanley J., St. Louis
Clark, Irving H., Kansas City
Clark, Kendall A., Jefferson City
Clark, Richard E., St. Louis
Clarke, Michael J., Springfield
Clary, William F., Springfield
Claseman, Wilma W., St. Louis
Clasen, Arthur C., Miami Beach, Fla. (Member Jackson County Medical Society)
Clawson, James W., Springfield
Clayton, Edgar L., Springfield
Cleary, Frank, St. Louis
Clendenin, William W., St. Louis
Clever, Henry W., Jr., St. Charles
Cline, Harold H., Piedmont
Cline, Merle A., Kansas City
Clisham, John F., Hannibal
Clothier, Robert W., Independence
Clough, Charles A., Kansas City
Co, Teddy G., Independence
Coates, Thomas A., St. Louis
Cobb, James R., Kansas City

Cobb, Sanford, Kansas City
Coben, Lawrence A., St. Louis
Coburn, Donald F., Kansas City
Cochran, Donald Q., Columbia
Cochran, Jo R., Cape Girardeau
Cochran, Thomas E., Jr., Springfield
Cochrane, Joseph J., Kansas City
Cockerell, Sanford F., Independence
Codilla, Sostenes G., High Ridge
Coffee, Amos L., Willow Springs
Cofer, T. N., Chillicothe
Coffey, Ralph R., Kansas City
Coffin, Theodore A., Kansas City
Coffman, Esther E. L., Lakeworth, Fla. (Member Ozarks Medical Society)
Cohen, Frank, St. Ann
Cohen, Harry K., Kansas City
Cohen, Hillard K., St. Ann
Cohen, Robert A., Kansas City
Cohen, Robert S., St. Louis
Cohle, Richard R., Carthage
Cohrs, Clarence C., Moberly
Cokingtin, Leovigildo, Independence
Cokrhame, Jack, Florissant
Colbert, Robert S., Sikeston
Colburn, R. Marshall, St. Louis
Cole, Harry O., St. Louis
Cole, Robert R., St. Louis
Cole, William R., Smithton
Colglazier, Mary C., Kansas City
Colier, Frederick B., Springfield
Collins, Gretchen D., Macon
Collins, John A., St. Louis
Collins, John M., St. Louis
Collins, John W., Kansas City
Collodi, George A., St. Louis
Colom, George A., Kansas City
Colosi, Nicholas J., St. Louis
Colwill, Jack M., Columbia
Comas, Manuel R., Manchester
Comeau, Richard A., Dexter
Comens, Phillip, St. Louis
Comens, Ruth C., St. Louis
Comer, J. Russell, Hannibal
Commerford, John F., St. Charles
Compton, James R., Sarasota, Fla. (Member St. Louis County Medical Society)
Cone, Alfred J., Chesterfield
Connelly, Michael W., Frontenac (Member St. Charles-Lincoln County Medical Society)
Conrad, Adolph H., Jr., Clayton
Conrad, Joseph A., Chillicothe
Conrad, Marshall B., St. Louis
Conrad, Raymond C., Springfield
Cook, James R., Springfield
Cook, Jerry W., Kansas City
Cook, Marvin A., Florissant
Cook, O. W., Caruthersville
Cook, Thomas B., Richmond
Cooper, C. Wesley, Springfield
Cooper, Charles W., Jefferson City
Cooper, Claude W., Thayer
Cooper, Henry T., St. Louis
Cooper, James F., Florissant
Cooper, Maurice E., Columbia
Cooper, R. Lee, Warrensburg
Cooper, Robert S., II, Warrensburg
Cooper, Theodore, Bethesda, Md. (Member St. Louis Medical Society)
Cooper, Thomas J., St. Louis
Cooper, Thomas P., St. Louis
Cope, James C., Columbia
Cope, Joseph S., Lexington
Copp, Ralph, St. Louis
Coppinger, Thomas A., Kansas City
Corday, Robert J., St. Louis
Cordonnier, James K., Springfield
Cordonnier, Justin, St. Louis
Coronado, Mario A., St. Louis
Corry, Francis M., Springfield
Cortner, Mary C., Kansas City
Corvalan, Juan C., Ballwin
Coscia, Robert L., Springfield
Costa, Dominic V., St. Louis
Costello, Cyril J., St. Louis
Costello, Joseph P., Jr., Brentwood
Costen, William S., St. Louis
Costrino, Joseph A., St. Louis
Cottey, J. H., Mexico
Cotton, Thomas R., Kansas City
Coulson, Forest H., Cape Girardeau
*Courter, Gary, Lebanon
Courter, Larry P., Jefferson City
Cova, Reno R., Jr., St. Louis
Cowan, George A. B., Kansas City
Cowdry, Edmund V., Jr., Creve Coeur
Cox, John P., St. Joseph
Cox, Kenneth E., Kansas City
Cox, Mary E., St. Louis
Cox, Robert D., St. Louis
Cox, William A., Jefferson City

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*Doctor of Osteopathy

Cox, William L., Liberty (Member Jackson County Medical Society)
Coxe, William S., St. Louis
Cozart, Duane E., Chesterfield
Cozean, Charles H., Jr., Cape Girardeau
Craft, George A., Columbia
Craig, Alan G., St. Louis
Craig, Irwin T., Joplin
Craig, Owen W. D., St. Joseph
Craig, Richard O., St. Joseph
Craig, Ronald D., Lincoln, Neb. (Member Perry-St. Genevieve County Medical Society)
Crain, James W., Branson
Cramer, Quentin, Parkville
Crane, John Bruce, Springfield
Craven, Thomas F., University City
Crawford, Archie L., Joplin
Crawford, Katherine J., University City
Crawford, Oral B., Springfield
Crawford, Robert M., Sullivan
Crayton, Billy G., Waverly
Creech, Joseph C., Troy
Cremer, William J., Fulton
Crespin, Stephen R., St. Louis
Crespo, Horacio T., Florissant
Crespo, Remedios R., Florissant
Crider, Russell J., St. Charles
Crighton, John C., Springfield
Criscione, James R., St. Louis
Criscione, James S., St. Louis
Crispell, Lawrence S., Joplin
Critchlow, Wm. C., Sikeston
Crocker, Albert M., Kansas City
Crockett, James E., Kansas City
Croom, Dorwyn W., Malden
Cross, Albert D., Trenton
Cross, Edward B., Kansas City
Crossman, Robert W., Webster Groves
Crosthwait, Ed L., Springfield
Crouch, F. Richard, Farmington
Crouch, Thomas T., Kansas City
Crow, Martin L., Kansas City
Crowe, John T., Cape Girardeau
Crowell, Hugh C., St. Louis
Crowley, Wm. J., Jr., Columbia
Crozier, Franklin A., Richmond
Cruz, Eligio C., St. Louis
Cruz, Sergio G., Jr., Monett
Csaki, Bela, Kansas City
Cubillo, Enrique, St. Louis
Cuento, Oblendo A., High Ridge
Culbertson, William F., Kansas City
Culley, Thomas S., Columbia
Cullum, Albert G. J., Middlesboro, Ky. (Member St. Louis County Medical Society)
Cunningham, Darral D., Springfield
Cunningham, E. J., Jr., St. Louis
Curran, Desmond, Kansas City
Curran, Kevin E., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Curry, Michael J., St. Charles
Curts, Calvin J., Kansas City
Cutcliff, Daniel J., Kansas City
Cutler, Harold M., St. Louis
Cutler, Harry, St. Louis
Czebrinski, Edward W., St. Louis

D

Daake, John W., St. Louis
Dabbs, Wilbur D., Neosho
Dagartzikas, A. K., Town & Country
Dahm, Charles H., Jr., St. Louis
Daley, Frank R., Hamilton
Dalton, Arthur R., St. Louis
Dalton, Timothy T., Kansas City
Dames, Richard J., St. Louis
Damron, Edward O., Elsberry
Damron, Oscar H., Warrensburg
Danforth, William H., St. Louis
Danielsson, Ernst P., Springfield
Danis, Peter G., St. Louis
Danis, Richard K., St. Louis
Dankner, Arnold, St. Louis
Dann, David S., Kansas City
Darnell, Dale E., Kansas City
Darnell, Thomas F. B., Columbia
Das, Arabinda, Belleville, Ill. (Member St. Louis County Medical Society)
Dash, Udaya N., St. Louis
Datta, N. K., Bonne Terre
Daughaday, William H., St. Louis
Daum, Harold F., Sedalia
Daut, Donald W., Mexico
Davault, George K., Richmond
Davidson, Kendrick C., Leawood, Kan. (Member Jackson County Medical Society)
Davidson, Morris, Clayton
Davis, C. Braxton, Nevada
Davis, Charles S., Joplin
Davis, David, Columbia
Davis, Donald R., Kansas City
Davis, Edgar W., St. Louis
Davis, Gustave L., St. Louis
Davis, Herbert V., Kansas City
Davis, Jack M., Kansas City
Davis, Kenneth A., Kansas City
Davis, Landis Y., Canton
Davis, Leonard L., Jr., Mexico
Davis, Martin W., St. Louis
Davis, Mary A., St. Louis
Davis, Wilbur L., Charleston
Davisson, Walter F., Jefferson City
Day, Maxwell, McAllen, Texas (Member Buchanan County Medical Society)
Deakin, Rogers, St. Louis
Dean, Francis D., Fayette
Decanini, Mario, St. Joseph
Deeken, James H., Kansas City
De Feo, Theodore C., Kansas City
DeGenova, Gerald H., Ste. Genevieve
Deitchman, Robert B., St. Louis
De Jesus, Alberto, St. Louis
de la Torre, John J., Sullivan
Del Carmen, Jaime J., Maryland Heights
DeLeon, Romualdo V., Arnold
Deles, Vicente D., Crystal City
Deleste, Carlos J., St. Louis
Deligeorges, John, Kansas City
DeLima, Clarence A., Columbia
Del Pizzo, Ferdinand, St. Charles
Del Rosario, Horacio O., St. Louis
Del Valle, Fernando, St. Louis
DeMaria, Peter F., Kansas City
DeMott, John D., Kansas City
DeMotte, John A., Kansas City
Dempsey, Herbert A., Lee's Summit
Denk, Alan F., St. Louis
Denninghoff, James C., Columbia
Dennis, W. Paul, Flat River
Dennison, Carl F., St. Louis
Dent, George W., Jr., Farmington
Denton, Robert E., Smithville
Dernoncourt, John E., Smithville
DeTar, Burleigh E., Joplin
Dettmer, Robert F., Ironton
de Ungria, Estelita Maria, St. Louis
de Ungria, Pablo Calma, St. Louis
Deutch, Max, St. Louis
de Vera, Anson E., St. Louis
Devgan, Baldev K., St. Louis
Devine, John B., St. Louis
Devine, Mark W., Jr., Kansas City
Devins, George S., Kansas City
DeVivo, Darryl C., St. Louis
Dew, Thomas A., St. Louis
Dewald, Paul A., St. Louis
DeWeese, Marion S., Columbia
Dewein, Edward G., St. Louis
Dexheimer, Frank R., Columbia
Dexter, James D., Columbia
Dickler, Donald J., St. Louis
Diehr, Maurice A., St. Louis
Diekroeger, Manuel L., Boonville
Deimer, Peter A., St. Louis
Dierker, H. D., Farmington
Diestelhorst, James A., Creve Coeur
DiLeo, Senatro W., Florissant
Dillard, Burl M., St. Louis
Dillard, Erin M., Springfield
Dills, Joseph N., Springfield
Dimond, E. Grey, Kansas City
Dinelli, Frank E., Poplar Bluff
Dinkins, James A., Cape Girardeau
Diveley, Rexford L., Kansas City
Dixon, George D., Kansas City
Dixon, John R., Brookfield
Dixon, Vewiser L., Kansas City
Dlabal, Luke J., Independence
Dlabal, Luke J., Jr., Kansas City
Dmytryk, Eugene T., St. Louis
Doane, William L., Kansas City
Dodge, Mark, Kansas City
Dodge, Philip R., St. Louis
Doerhoff, Adelia, Jefferson City
Doerhoff, Allan, Jefferson City
Doering, Robert W., Kansas City
Doisy, Philip P., St. Louis
Doisy, Robert A., Glendale
Dolan, C. Terrance, N. Kansas City (Member Clay County Medical Society)
Dolan, Daniel L., Springfield
Dolan, John T., Jr., St. Louis
Domann, Darrel D., Springfield
Domke, Herbert R., Jefferson City (Member Callaway County Medical Society)
Donaldson, Robert C., St. Louis
Donati, Robert M., St. Louis
Donegan, Judith H., Columbia
Donegan, William L., Columbia
Donley, Leo F., Jr., St. Louis
Donley, Robert R., Monett
Donnell, Harold E., De Soto
Donnell, Robert H., Crystal City
Donnell, Thomas A., De Soto
Dooley, Joseph M., Jr., St. Louis
Dorsch, Ervin H., Independence
Dorton, Robert K., St. Louis
Doucette, Raymond C., St. Louis
Dowell, George H., St. Louis
Dowell, J. Larry, Pattonsburg
Downey, James W., Kansas City
Downey, Jon Patrick, Cape Girardeau
Doyle, Charles R., St. Louis
Doyle, Matthew J., Kansas City
Drace, Charles C., Jr., St. Louis
Drake, Avery A., Phoenix, Ariz. (Member Mid-Missouri County Medical Society)
Drake, Roy F., Kansas City
Drake, William L., Jr., St. Louis
Draney, Thomas E., Kansas City
Draper, Bernard, Rolla
Dreher, Richard L., Kansas City
Drescher, Emmett B., St. Louis
Drews, Robert C., St. Louis
Drey, Norman W., St. Louis
Dreyer, Carl J., Webster Groves
Dreyer, Philip V., Huntsville
Dreyer, William F., Houston
Drisko, Robert M., Kansas City
Drowns, Bruce V., Kansas City
Drum, Helen M., St. Louis
Drury, Lawrence R., Chicago, Ill. (Member Jackson County Medical Society)
Dubuque, Theodore J., Jr., St. Louis
Duemler, Robert H., Kirkwood
Duer, Mildred C., Kansas City
Duffy, Francis G., St. Louis
Duffy, Oliver F., Trenton
Duggan, John J., Jr., Kirkwood
Dukstein, Walter G., Kansas City
Dulick, Michael, Brentwood
Duling, Gerald J., St. Charles
Dumadag, Virgilio P., Chesterfield
Dumonceaux, Leonard J., St. Charles
DuMont, Clement C., St. Joseph
DuMontier, R. J., O'Fallon
Dunaway, Howard A., Sikeston
Duncan, David, St. Charles
Duncan, Robert D., Springfield
Duncan, Wm. H., Kansas City
Dunham, Robert H., N. Kansas City
Dunleavy, James D., Kansas City
Dunmire, George Q., Kennett
Dunn, Robert E., St. Louis
Dunshee, Robert E., Maryville
DuPont, Jean-René, Sikeston
Durnell, Monaford D., Lee's Summit
Durr, Jon W., Columbia (Member St. Louis County Medical Society)
Durst, Henry, Fulton
Dworkin, Saul, St. Louis
Dwyer, Frank X., Kansas City
Dwyer, Hugh L., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Dwyer, Thomas L., Mexico
Dyer, Dallas J., St. Louis
Dyer, Gary A., Columbia
DyRagos, Ramon R., Kansas City (Member Clay County Medical Society)
Dzundzev, Penco, St. Louis

E

Eachempati, Rama G., St. Louis
Eachempati, Uma R., Chesterfield
Eades, Dee W., St. Louis
Eades, Joseph W., St. Louis
Eagleton, Mark D., St. Louis
Earnest, James B., Kansas City
Earp, Ralph K., St. Louis
Ebel, Eugene H., Florissant
Eberle, Vincent L., St. Louis
Eck, Birkle, St. Louis
Ecker, Decider, Pacific
Eckert, Clarence T., Sarasota, Fla. (Member St. Louis Medical Society)
Ecklund, Archibald M., San Diego, Calif. (Member St. Louis Medical Society)
Ector, Henry J., Mexico
Edele, Eugene H., St. Louis
Edelman, Alan H., St. Louis
Edison, John M., Springfield
Edmond, Beauvoir H., St. Louis
Edmonds, Robert W., Sedalia
Edwards, D. R., Sedalia
Edwards, Donald E., Cape Girardeau
Edwards, James E., Clayton
Edwards, Joseph C., St. Louis
Edwards, Theodore F., Kansas City
Edwards, Waldo B., Kirkwood
Efstathianos, Kimon, St. Louis
Egan, Robert C., St. Louis
Egan, Thomas F., St. Louis
Egea, Fernando M., Kansas City, Kan. (Member Jackson County Medical Society)

Eggers, George W. N., Jr., Columbia
Eggleston, Donald E., Macon
Eggleston, Harry C., St. Louis
Eggleston, Thomas F., St. Louis
Ehrlich, Carl F., Jr., St. Louis
Eidelman, Jack R., St. Louis
Eigel, Edwin G., St. Louis
Eimer, Charles E., St. Louis
Eisemann, Gustave, Kansas City
Eisen, Arthur Z., St. Louis
Eisenmann, Benjamin P., New Haven
Ekern, H. Peter, Mexico
Eklund, Alfred W., Pleasant Hill
Eldenburg, Donald, Sedalia
Elders, Frank A., Jr., Cuba
Elhassani, Sami B., Sedalia
Elias, David J., Independence
Eliasson, Sven G., St. Louis
Eliscu, Juliette, Joplin
Elkadi, Ahmed, Springfield
Elkins, Ronald F., Springfield
Eller, C. Howe, St. Louis
Ellersieck, Dorothy M., St. Louis
Ellett, William H., Appleton City
Ellfeldt, Howard J., Kansas City
Elliott, Raymond G., Kansas City
Elliott, Wade E., Kansas City
Ellis, Francis J., Springfield
Ellis, Harry L., Springfield
Ellison, Leroy E., Warren, Ark. (Member St. Louis County Medical Society)
Ellsasser, James C., St. Louis
Ellsworth, Willard, Cainsville
Elrod, Dennis B., Cape Girardeau
Elser, Otto H., Independence
Elson, Julius, St. Louis
El'Toumi, Ahmed A., St. Louis
Emeran, George, St. Louis
Emerson, Reynolds L., St. Louis
Emery, Frank E., Springfield
Engel, Lawrence P., Shawnee Mission, Kans. (Member Jackson County Medical Society)
Engelhardt, Robert C., Poplar Bluff
Engelmann, Calvin E., Kansas City
Engleman, Reinhold, Kansas City
English, Milton T., Jr., Kirksville
English, Wallace D., Cardwell
Ericcson, Samuel E. F., Kansas City
Erickson, H. John, Sedalia
Ernst, Edwin C., Jr., St. Louis
Ernst, Joseph G., St. Louis
Ernst, Richard E., St. Louis
Ernst, Roland P., St. Louis
Escobedo, Bolivar M., St. Louis
Eshelman, Albert D., Independence
Esparrago, Francisco R., Jr., Monett
Espinosa, Tomas, Fulton
Esslinger, Arthur T. J., St. Louis
Essmyer, Joseph K., Cape Girardeau
Estes, Jack M., St. Louis
Esther, John R., Joplin
Estrada, Corazon deLeon, St. Louis
Estrada, Jesus I., St. Louis
Etienne, Robert B., St. Louis
Eto, Jackson, St. Louis
Eubank, David F., Kansas City
Eubank, Dillard M., Raytown
Eubank, William Y., Kansas City
Eugenio, Romeo R., Perryville
Euprasert, Pricha, Blue Springs
Evans, Elizabeth A., Kansas City
Evans, Ezra L., Jr., Springfield
Evans, Lawrence L., Kansas City
Evens, Ronald G., St. Louis
*Everett, James E., Kansas City
Eversoll, Norton J., Hollywood, Fla. (Member St. Louis County Medical Society)
Exarhou, Klark, Florissant
Exon, C. Stuart, Jefferson City
Eyerman, Edward L., Jr., St. Louis
Eyermann, Charles H., St. Louis
Eyermann, H. Walter, Warrenton

F

Fabian, Leonard W., St. Louis
Fabito, Daniel C., St. Louis
Fabito, Melinda A., Eureka (Member St. Louis County Medical Society)
Fair, William L., Chillicothe
Fairchild, James F., Perryville
Fairchild, Robert C., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Fakhoury, Donald A., Kansas City
Fallon, Richard H., St. Louis
Farley, Claude C., Kansas City
Farmer, Norma D., Farmington
Farney, Jacob P., Kansas City
Farnham, Milo M., Independence
Farnsworth, Jesse J., Kansas City
Farrales, Franklin B., Kansas City
Farrell, Frank W., St. Louis
Farrell, Robert J., St. Louis
Farrell, S. L., Washington
Farthing, Gene W., Springfield
Fathman, Anthony E., St. Louis
Fayez, Jamil A., Kansas City
Fayne, Fred A., Kansas City
Fee, Chester F., Kansas City
Feeley, Donald R., Ballwin
Fehlman, Bernard F., Jr., St. Louis
Feibel, Robert M., St. Louis
Feigin, Ralph D., St. Louis
Feind, Earl E., Rolla
Feist, George V., Kansas City
Feist, Wm. Edgar, Kansas City
Felder, James P., St. Charles
Feldman, David, St. Louis
Felix, Robert H., St. Louis
Feller, Harold H., St. Louis
Fellhauer, Carl M., St. Louis
Felts, James A., St. Louis
Feltz, Lawrence W., Perryville
Ferguson, Donald S., Kansas City
Ferguson, John L., Springfield
Ferguson, John P., Jr., Springfield
Ferguson, L. H., Jr., Alexandria, La. (Member Jasper County Medical Society)
Ferguson, Luther J., St. Joseph
Ferguson, Ralph L., Joplin
Ferguson, Robert M., Joplin
Ferguson, Thomas B., St. Louis
Ferneau, James E., Columbia
Ferrara, John P., Chesterfield
Ferreira, Afonso C., St. Louis
Ferrell, Thomas E., Jr., Springfield
Ferrendelli, James A., St. Louis
Ferris, Carl R., Kansas City
Ferro, Anthony L., St. Louis
Ferry, Richard J., St. Louis
Fetick, Paul G., St. Louis
Figueroa, Elisio O., St. Louis
Files, James B., Jefferson City
Finger, Donald H., St. Louis
Fingerhood, Marvin G., St. Louis
Fingert, Hyman H., St. Louis
Fink, LeRoy L., Florissant
Fink, Roger L., Springfield
Finkel, Barney W., St. Louis
Finkle, Robert H., Independence
Finley, Freeman L., St. Louis
Finn, Murray E., St. Louis
Finnegan, Joseph V., St. Louis
Fischer, Charles K., Richton Park, Ill. (Member St. Louis Medical Society)
Fischer, Edward H., Kansas City
Fischer, Erich, St. Louis
Fischer, John R., Clayton
Fischer, Jose, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Fischer, Martin J., St. Joseph
Fischer, Theodore, Altenburg
Fischer, Thomas J., Hannibal
Fish, Richard., St. Louis
Fish, Virgil O., St. Louis
Fisher, James K., Overland Park, Kan. (Member Jackson County Medical Society)
Fisher, Joseph L., St. Joseph
Fisher, Stanley D., Sedalia
Fishman, John J., St. Louis
Fishman, Marvin A., St. Louis
Fitch, C. H. Max, Springfield
Fitch, Coy D., St. Louis
FitzGerald, Leo P., St. Louis
Fitzgerald, Robert H., Kansas City
Fitzgerald, William T., St. Louis
FitzSimmons, James G., Kansas City
Fivian, Gerald J., St. Louis
Flance, Israel J., St. Louis
Flanders, Virgil E., Leawood, Kan. (Member Clay County Medical Society)
Flanigan, George D., Jr., St. Louis
Flatley, John A., Kansas City
Flavan, David B., St. Louis
Fleishman, Alfred, St. Louis
Fleming, Allan R., Kansas City
Fleming, J. Will, Moberly
Fleming, Robert J., St. Charles
Fleming, Thomas S., Moberly
Fletes, James W., St. Louis
Florendo, Federico N., Jr., Hannibal
Florendo, Purificacion T., St. Louis (Member Marion-Ralls-Shelby County Medical Society)
Flores-Vega, Carlos H., St. Louis
Floro, Mariano N., Florissant
Flotte, Bernard H., St. Louis
Flotte, Sylvester A., Florissant
Flynn, Edward P., St. Louis
Flynn, James M., Kansas City
Flynn, John T., St. Louis
Flynn, Joseph E., St. Louis
Flynn, Thomas T., St. Louis
Fogarty, William M., Jr., St. Louis
Fogerson, Virginia L., Springfield
Fogle, Philip R., Springfield
Folck, William P., Kansas City
Folkner, A. L., Warrensburg
Foote, Jerry E., Columbia
Ford, Lee T., Jr., Belleville, Ill. (Member St. Louis Medical Society)
Ford, Thomas E., St. Louis
Ford, William, Farmington
Foreman, Phillip B., Hannibal
Forgrave, Leon P., St. Joseph
Forman, George W., St. Joseph
Forman, Louis H., Kansas City
Forsen, James A., Gower
Forsman, Waldo W., Jr., St. Louis
Forsyth, B. Todd, St. Louis
Forsythe, Lees C., Kansas City
Forsythe, Robert W., Kansas City
Forti, John J., St. Louis
Fotopoulos, Chris K., North Kansas City
Fouts, Dallas B., Sr., Independence
Fowler, Fred D., Kansas City
Fowler, I. Charles, N. Kansas City
Fowler, James W., Kansas City
Fowler, Marvin L., West Plains
Fox, Gerald E., St. Joseph
Fox, Leon J., St. Louis
Fox, Robert E., St. Louis
Francis, William C., Springfield
Francisco, Clarence B., Kansas City
Francisco, Edgardo C., Nevada
Franco, Pilar Juan, Kansas City
Frank, Alvin R., St. Louis
Frank, Gael R., Kansas City
Franklin, Curtis U., Kansas City
Franklin, Harold A., St. Louis
Franklin, Max S., St. Louis
Fraser, Daniel M., St. Louis
Fraser, Richard A., Poplar Bluff
Frawley, Thomas F., St. Louis
Frazier, Robert E., Columbia
Frederick, Raymond O., St. Louis
Freedman, Harold, St. Louis
Freedman, Ruth S., St. Louis
Freeman, David M., St. Louis
Freeman, Jerry C., Kansas City
Freeman, Spencer L., Kirksville
Freiheit, Harold J., St. Louis
Freiman, S. Michael, St. Louis
Freimuth, L. E., St. Louis
Frein, Donald E., Harrisonville
Freund, Samuel J., St. Louis
Frick, John P., Kansas City
Fried, Frederick E., Columbia
Friedman, Bernard, St. Louis
Friedman, Ira J., St. Louis
Friedman, Morris L., Kansas City
Friedman, Paul L., St. Louis
Friedman, Robert H., St. Louis
Friedrich, Ernst R., St. Louis
Fries, Armand D., St. Louis
Fries, John W., St. Louis
Friskel, Arthur K., St. Louis
Fritsch, Andrew J., Joplin
Fritzlen, Thomas J., Kansas City
Froelich, Edwin J., Lebanon (Member St. Louis County Medical Society)
Froelich, R. W., Lebanon
Frueh, Bartley R., Columbia
Frumson, Guy H., St. Louis
Fryer, Minot P., St. Louis
Fuchs, George J., Barnett
Fuchs, George J., Jr., Columbia
Fuhrman, Donald L., Kansas City
Fujita, Milton T., St. Louis
Fuleihan, Farid, St. Louis
Fulks, Richard B., California
Fullgrabe, Emil A., Jefferson City
Funsch, Robert E., St. Louis
Furla, Gus J., St. Louis
Furlow, Leonard T., Crystal River, Fla. (Member St. Louis Medical Society)
Fury, Tex E., Kansas City
Fuson, Levi H., St. Joseph
Fuson, William A., Trenton

G

Gafney, George T., St. Louis
Gagliardo, Joseph, St. Louis
Gaines, Albert, Kansas City
Gaines, Quentin M., Kirkwood
Gainey, Harold L., Kansas City
Gaitonde, Mangesh R., Kansas City
Galbol, Harley, Excelsior Springs
Galbreath, Ashford M., Kansas City
Gale, Arthur H., Overland
Gale, Joseph F., Chillicothe
Gale, Philip R., St. Louis
Galeota, William R., Columbia

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* Doctor of Osteopathy.

Galinsky, Leon J., Republic
Gall, Ira, St. Louis
Gallagher, Lionel M., California
Gallagher, Neil I., St. Louis
Galvez, Sisenande P., Jr., Marceline
Gammel, George E., Columbia
Gandlmayr, Jack M., St. Louis
Gansloser, Wilbert M., Clayton
Gantner, George E., Jr., St. Louis
Gantz, John A., St. Louis
Gapasin, Ernesto, Lebanon
Garcia, Charles L., Mexico
Garcia, Francisco, St. Louis
Gard, Raymond F., Wichita, Kan. (Member Jackson County Medical Society)
Gardner, Joseph A., Joplin
Gardner, Joseph W., Kimberling City
Garfinkel, Bernard T., St. Louis
Garner, James H., Kansas City
Garner, Lynn M., Jefferson City
Garner, Royal S., Jefferson City
Garrett, Glen H., Columbia
Garrison, David L., St. Joseph
Garrison, Norman A., Jr., Corinth, Miss. (Member Dunklin County Medical Society)
Garrison, Roy F., Kansas City
Garrison, T. W., Seoul, Korea (Member Mid-Missouri County Medical Society)
Garotto, Lewis J., Columbia
Gary, George, Marceline
Gaska, Walter J., Springfield
Gaskins, John H., Kansas City
Gass, Michael, Adidome, V. R. Ghana (Member St. Louis Medical Society)
Gaston, Samuel Lee, Joplin
Gauer, Robert J., Kansas City
Gaunt, Frank P., Webster Groves
Gaunt, William D., Columbia
Gauthier, Charles P., Kansas City
Gay, Elizabeth K., Florissant
Gearhart, David L., St. Louis
Gearhart, Merriam, Bethany
Gearhart, Wilbur H., St. Louis
Gedney, William B., Valley Park
Geha, Alexander S., St. Louis
Geha, Braham J., Kansas City
Geiger, William A., Jr., Kansas City
Geise, August W., Jr., St. Louis
Gellman, Elliott F., St. Louis
Gempel, Paul A., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Gentry, Enoch N., Jr., Kansas City
Gentry, Marvin C., Ava
Gentry, Merritt L., Jefferson City
Gentry, Michael A., Springfield
Gentsch, Kenneth W., Glendale
George, Theodore, Marceline
Gerdes, John A., Springfield
Gerdes, Joseph R., Kansas City
German, Walter A., Jr., Springfield
Germann, Donald R., Kansas City
Germuth, Frederick G., Jr., St. Louis
Gernstetter, Sangwill L., Poplar Bluff
Gerowin, Lance, St. Louis
Gerst, Aloysius C., Florissant
Giannellis, C., St. Louis
Gibson, David M., Kansas City
Gibson, Helen F., St. Louis
Gibstine, Marvin H., St. Ann
Giddings, Frank C., Springfield
Giem, Ross N., Pasadena, Calif. (Member St. Louis County Medical Society)
Gieselman, Ralph V., St. Louis
Giesler, Donald H., Osceola
*Giffen, L. E., Jefferson City
Giffin, James M., Springfield
Gifford, Christopher G., Sikeston
Gilani, Abdollah, N. Kansas City (Member Clay County Medical Society)
Gildea, Edwin F., St. Louis
Gildea, Margaret C. L., St. Louis
Gilden, Jerome J., St. Louis
*Gilgore, Alfred, Lenexa, Kan. (Member Jackson County Medical Society)
Gillespie, William J., Idaho Falls, Idaho (Member St. Louis Medical Society)
Gilliland, Charles E., Cameron
Gillispie, Roy, Branson
Gilpin, Doris C., St. Louis
Gilula, Louis A., St. Louis
Ginardi, Donald E., Kansas City
Ginsberg, Norman A., Kansas City
Giraparnont, Bang Orn, Clayton
Giraparnont, Prabhak, St. Louis
Gish, Rutledge, Fulton
Gist, William W., Kansas City
Givler, Robert L., Kansas City
Gladney, John H., St. Louis
Glaser, Larry F., Kansas City
Glasgow, David S., Crystal City
Glass, Robert L., Sedalia
Glass, William J., Jr., Monett
Glasscock, Ernest L., Prairie Village, Kan. (Member Jackson County Medical Society)
Glazer, Melvin L., Kansas City
Glover, Jack F., Springfield
Glover, Kenneth, Mt. Vernon
Gnade, Albert J., St. Louis
Goebel, Joan M., St. Louis
Goell, Robert S., St. Louis
Goerz, Ann F., Independence
Goerz, Royal D., Independence
Gohil, Jivanlal P., Columbia
Goldberg, Isadore E., Braymer
Goldenson, Max J., St. Louis
Goldfarb, Alvin, St. Louis
Goldkamp, John D., St. Charles
Goldman, Arnold M., St. Louis
Goldman, Gordon M., St. Louis
Goldman, Hyman J., St. Louis
Goldman, Melvin L., St., Louis
Goldman, Stanley L., Kansas City
Goldring, Sidney, St. Louis
Goldsich, Edward, Kansas City
Goldstein, Marcy A., St. Louis
Goldstein, Marvin F., Kansas City
Gollub, Samuel W., St. Louis
Gomez, Cesar A., Jr., St. Louis
Gonzalez, M. Garza, Warrensburg
Goodman, J. N., St. Louis
Goodman, Nathaniel, St. Louis
Goodrich, Harold A., Webster Groves
Goodson, Wm. H., Jr., Kansas City
Goodwin, Donald W., St. Louis
Goolsbee, Robert L., Kansas City
Gordon, James S., Jefferson City
Gordon, Morris P., Kansas City
Gore, Glenn L., St. Charles
Gorelick, David F., Springfield
Gorla, Wayne O., St. Louis
Gose, Don F., Springfield
Gottsch, Joseph C., Kansas City
Gowdamarajan, Rengasamy, Kansas City
Gowler, Douglas R., St. Louis
Grabau, Gene H., St. Louis
Grable, James D., Portageville
Grabowski, Marie H., Nanticoke, Pa. (Member Jackson County Medical Society)
Grabske, Charles F., Independence
Grady, Ronald K., St. Louis
Graff, Ralph J., St. Louis
Graham, Patrick G., Kansas City
Graham, Wallace H., Kansas City
Graneto, Joseph A., St. Louis
Grant, Claude S., St. Joseph
Grant, John M., St. Louis
Grant, Neville, St. Louis
Grant, Samuel B., St. Louis
Graul, Walter P., St. Louis
Graves, Arthur J., Mt. Vernon
Gray, Mary Louise, St. Louis
Gray, Walter C., St. Louis
Grebel, Clement B., St. Louis
Green, J. Richard, Independence
Green, Manuel E., St. Louis
Green, Morton R., Belleville, Ill. (Member St. Louis Medical Society)
Green, William R., St. Louis
Greenberg, Charles, Los Angeles, Calif. (Member Buchanan County Medical Society)
Greene, Harry L., Hannibal
Greene, W. Wallace, Kansas City
Greenlund, Nelson, Nevada
Greenman, Marshall B., St. Louis
Gregory, John G., St. Louis
Gregory, Ralph W., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Gresick, Robert J., St. Louis
Griege, Charles W., Florissant
Griffin, Donald R., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Griffin, Evelyn, Buffalo
Griffin, Olin A., Jr., Buffalo
Griffin, William T., Columbia
Griffith, John A., Jr., Kansas City
Griggs, James Y., St. Louis
Grim, Edward M., Joplin (Member North Central Counties Medical Society)
Grim, George B., Warrenton
Grimes, Manning E., St. Joseph
Grindon, Joseph B., St. Louis
Grinstein, Alberto, St. Joseph
Groce, George, Fulton
Gronau, Axel R., St. Louis
Grossman, Joel S., Kansas City
Grossman, Marvin, Fredericktown
Grove, Gulp W., Knobnoster
Growdon, John A., Kansas City
Grubb, Paul H., Joplin
Grubb, Robert L., St. Louis
Gruenfeld, Gerhard E., St. Louis
Grundmann, William H., St. Louis
Grunt, Jerome A., Kansas City
Guastello, Mario J., Kansas City
Gubin, Alan S., Caruthersville
Guccione, Joseph B., St. Louis
Guhleman, Henry V., Jr., Jefferson City
Guldner, Edmond, Lamar
Gulick, Charles R., St. Louis
Gullett, Charles C., Kansas City
Gummels, Belmont B., St. Louis
Gundle, Sigmund, Kansas City
Gunn, Jack, Versailles
Gunn, Richard W., Kansas City
Gunn, Walter T., St. Louis
Gunter, Joe S., St. Joseph
Gupta, Jitendra K., St. Louis
Gupta, B. S. N., Kansas City
Gupta, Narayan C., St. Louis
Gurnee, Landon H., Jefferson City
Gursahani, Man Mohan, Creve Coeur
Gustafson, Jon E., Independence
Guze, Samuel B., St. Louis

H

Haas, Harry D., Kansas City
Habib, Henry N., Kansas City
Haddock, James N., Webster Groves
Haen, Charles J., Springfield
Haffner, Heinz, St. Louis
Hagan, Daniel J., St. Louis
Hagar, David L., Kansas City
Hagebusch, Omer E., St. Louis
Hagemann, Paul O., Clayton
Hagen, Duane, St. Louis
Hahn, Frederick W., Jr., Kansas City
Haight, John M., Kansas City
Haith, Edward E., Kansas City
Haith, Walter F., Kansas City
Haley, Ted M., N. Kansas City
Hall, C. Robert, Versailles
Hall, David G., Columbia
Hall, David W., Rogersville
Hall, Durward G., Springfield
Hall, Eugene W., Ferguson
Hall, Lee A., Clayton
Hall, Marvin F., Joplin
Hall, Preston C., St. Louis
Hall, Ralph R., Kansas City
Hall, Robert A., St. Louis
Hall, Robert T., Kansas City
Hall, Stanley G., Hannibal
Hall, Thomas B., Arrow Rock (Member Jackson County Medical Society)
Hall, William K., St. Charles
Hallaba, M. A. S., Joplin
Hallazgo, Santiago Y., Chesterfield
Halley, Robert H., Florissant
Hallinger, Earl S., Jr., St. Louis
Halloran, Mark J., St. Louis
Halperin, Phillip H., Kansas City
Hamburg, Frederic L., Springfield
Hamill, Robert W., Kansas City
Hamilton, Caldwell K., Creve Coeur
Hamilton, Eugene G., Clayton
Hamilton, Eugene H., St. Louis (Member Jasper County Medical Society)
Hamilton, Thomas R., Duluth, Minn. (Member St. Louis Medical Society)
Hamilton, William P., Aurora
Hamilton, Wm. P., St. Louis
Hamlin, Howard H., Kansas City
Hamlin, Wyeth, Hannibal
Hammes, Roman E., St. Charles
Hammler, Christiana V., St. James
Hammond, D. Wade, St. Charles
Hammond, David T., St. Louis
Hampton, Henry E., St. Louis
Hampton, Oscar P., Jr., St. Louis
Hampton, Stanley F., St. Louis
Hanan, Ernest B., Springfield
Handler, Eric, St. Joseph
Handler, Fred P., Jefferson City
Hankin, Norman M., St. Louis
Hanna, Fayez, St. Louis (Member St. Charles-Lincoln County Medical Society)
Hanna, Hugh A., Warrensburg
Hanna, Richard E., St. Louis
Hansbrough, Eugene T., Poplar Bluff
Hansel, French K., St. Louis
Hansen, Arthur L., Butler
Hanser, Theodore H., St. Louis
Hanson, Karl H., Jr., Kansas City
Hanss, Armand W., Springfield
Hantman, Stephen L., Chesterfield
Hantz, Oscar, Florissant
Hardacre, Ruth A., Kansas City
Hardin, William B., Jr., St. Louis
Hardwicke, Henry M., Ashland
Hardy, David A., St. Louis
Hardy, Guerdan, Clayton

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*Doctor of Osteopathy

Hardy, Henry M., Kansas City
Hardy, John W., Kansas City
Hardy, Patrick J., Florissant
Hardy, Stanton L., Desloge
Harell, Alex, St. Louis
Harford, Carl G., St. Louis
Harkins, William B., St. Louis
Harkness, Harry, Winston-Salem, N. C. (Member Johnson County Medical Society)
Harland, Robert E., La Jolla, Calif. (Member Mineral Area County Medical Society)
Harless, Morris S., Kansas City
Harlow, Lloyd M., Kansas City
Harmon, Ben C., Springfield
Harms, Florian L., Salisbury
Harms, James F., Nevada
Harned, Bert W., Olathe, Kan. (Member Jackson County Medical Society)
Harner, Casper G., St. Joseph
Harper, Fleming B., St. Louis
Harrell, Henry J., Summerfield, Fla. (Member Dallas-Hickory-Polk-Dade County Medical Society)
Harrin, William R., Kansas City
Harris, Hugh S., Jr., Columbia
Harris Lanny W., Kansas City
Harris, Robert J., Columbia
Harris, Solon P., St. Louis
Harrison, Lee B., St. Louis
Harrison, Richard L., Crestwood
Harrison, Stratton W., Springfield
Harrison, Winston E., Columbia
Hart, L. Wayne, Kansas City
Hart, William M., Columbia
Harting, Hugh R., St. Louis
Hartman, Paul T., St. Louis
Hartnett, Leo J., St. Louis
Hartnett, Thomas D., St. Louis
Hartstein, Jack, St. Louis
Hartwig, Frederick H., Kansas City
Hartwig, John A., St. Louis
Hartwig, Raymond W., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Harvey, Harold D., Springfield
Harwell, J. Larry, St. Louis
Harwell, J. Lester, Lubbock, Tex. (Member Butler-Wayne-Ripley County Medical Society)
Hasek, James A., Mountain Grove
Hasek, O. Martin, Mountain Grove
Hasenmueller, James J., St. Louis
Hata, Daikichi, Boonville
Hatfalvi, Bela I., St. Louis
Hauser, Robert J., Jefferson City
Hausheer, Herman J., Independence
Haw, Marvin T., Jr., Columbia
Hawk, Bray O., St. Louis
Hawker, William D., St. Louis
Hawkins, George L., Jr., St. Louis
Hayek, Wesley E., Florissant
Hayes, Lawrence L., Kansas City
Hayes, Paul W., St. Joseph
Haynes, James W., St. Louis
Haynes, Solon E., Kansas City
Haynie, William W., Butler
Hazen, Robert M., Kansas City
H'Doubler, Charles E., Springfield
H'Doubler, Francis T., Jr., Springfield
H'Doubler, Peter B., Springfield
Headrick, John A., Florissant
Hecker, Joseph E., Poplar Bluff
Hedges, Richard C., Excelsior Springs
Heeb, Max A., Sikeston
Heideman, Milo L., St. Louis
Heilbrunn, Ilse, Rolla
Heilman, Edward J., Kansas City
Heiman, Avivi, St. Louis
Heimburger, Richard A., Columbia
Heins, James N., St. Louis
Helbing, Edward J., Rio Rancho Estates, N. M. (Member St. Louis County Medical Society)
Hellerstein, Stanley, Kansas City
Hellweg, Charles E., Mt. Vernon
Hellweg, Raymond W., Florissant
Helman, Richard G., Kansas City
Henares-Levy, L., St. Louis
Henderlite, John W., St. Louis
Hendin, Aaron, Olivette
Hendren, Thomas H., N. Kansas City (Member Clay County Medical Society)
Hennelly, John J., St. Louis
Henry, Clarke Latta, Kansas City
Henry, Lawrence D., Columbia
Henry, Robert D., Harrisonville
Henschel, Eugene V., St. Louis
Her, Kyu Sook, St. Louis
Herbert, Charles T., Cape Girardeau
Herdoiza, Alfonso W., Kansas City
Herfkens, Kenneth D., Springfield
Herjanic, Marijan, St. Louis
Herman, Allen I., St. Joseph
Herman, Edwin M., Kansas City
Herman, Morris, St. Louis
Hernandez, Salvadore, St. Louis
Herrman, George V., Kansas City
Hershey, Falls B., St. Louis
Hertel, Ronald C., St. Louis
Hervey, Wm. H., II, Kansas City
Heryer, John W., Kansas City
Herzog, Godofredo M., Florissant
Hetlage, Louis P., Troy
Heusler, Anton F., St. Louis
Heutel, Lee B., St. Louis
Hibbard, Blaine Z., Kansas City
Hickcox, John P., Columbia
Hickerson, William H., Independence
Hickey, Glenn M., Manchester
Hickey, James L., St. Louis
Hicks, Robert S., St. Louis
Higgins, Philip C., St. Louis
Higgins, Ronald A., Kansas City
Hightower, Harry G., St. Louis
Hilbert, Paul H., St. Louis
Hildreth, H. Rommel, St. Louis
Hill, George J., St. Louis
Hill, Jack H., Kansas City
Hill, James E., Fulton
Hill, Ronald T., Dexter
Hill, XaCadene A., St. Louis
Hilliard, Alphonso W., St. Louis
Hillman, Richard E., St. Louis
Hills, Joseph E., Springfield
Hilton, Paul E., Joplin
Hinds, R. David, Hannibal
Hink, Frederick W., Independence
Hironimus, John, St. Louis
Hirsch, Joe E., Kansas City
Hite, Dennis E., Lebanon
Ho, Grinny H. C., Sikeston
Hoadley, William D., Kansas City
Hobbs, George H., Warrensburg
Hobbs, John E., St. Louis
Hoctor, Emmett F., Farmington
Hodge, Robert H., Kansas City
Hodgson, Frank H., Kansas City
Hodgson, Sheila, Columbus, Ohio (Member St. Louis Medical Society)
Hoech, George P., Jr., Kansas City
Hoelscher, Harold F., Warrenton
Hoeper, Samuel D., Grandview
Hoffman, Jacob S., Kansas City
Hoffmann, Alan L., Kansas City
Hoffmann, Augustin D., St. Louis
Hoffmann, Lee Martha, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Hoffmann, Ronald E., St. Louis
Hofling, Charles K., St. Louis
Hofmeister, Roger W., Columbia
Hofstatter, Leopold, St. Louis
Hogan, Cornelius E., St. Louis
Hogan, Daniel F., Brownsville, Texas (Member Jackson County Medical Society)
Hogan, John R., St. Louis
Hogan, Patrick A., St. Louis
Hogan, Patrick C., St. Louis
Hogancamp, Glenn E., Ellisville
Hoja, W. Alexander, Poplar Bluff
Holbrook, Charles K., St. Louis
Holcomb, John K., Cape Girardeau
Holder, Thomas M., Kansas City
Holemon, R. Eugene, St. Louis
Holland, Robert D., Springfield
Holley, Donald B., Camdenton
Hollinger, Lloyd A., Kansas City
Hollingsworth, Ray S., Clinton
Hollis, Richard W., Springfield
Hollo, Vencel W., St. Louis
Hollocher, Richard J., Creve Coeur
Holloway, Robert B., St. Louis
Hollweg, Kenneth C., Kansas City
Holmes, Daniel E., Springfield
Holmes, David R., Springfield
Holscher, Edward C., St. Louis
Holt, Earl P., Jr., St. Louis
Holt, Waldo S., Kansas City
Holt, William E., St. Louis
Holton, Edward B., Independence
Holtz, Alan S., Kirkwood
Holtz, Sumner, St. Louis
Holtzman, Samuel, Chicago, Ill. (Member Jasper County Medical Society)
Hook, Waller G., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Hookerman, Bruce J., St. Ann
Hoover, Bernard L., St. Louis
Hoover, H. Lee, Jr., Springfield
Hopkins, Florian G., Gideon
Hopkins, James P., Kansas City
Hopkins, Thomas J., Sedalia
Hopkins, T. Spencer, Sedalia
Horenstein, Simon, St. Louis
Hori, Jose M., Moberly (Member Boone County Medical Society)
Horn, Paul C., Cape Girardeau
Horner, John L., St. Louis
Hornstra, Robijn K., Kansas City
Horrilleno, Emilio G., St. Louis
Horton, James D., Springfield
Horwitz, Irwin B., St. Louis
Houck, Russell M., Kecoughtan, Va. (Member Clay County Medical Society)
Houston, Vincent T., St. Louis
Hovadhanakul, Praphat, St. Louis
Howden, Thomas L., St. Joseph
Howe, Albert L., St. Louis
Howe, Louis F., St. Louis
Howell, Billy D., Brookfield
Hoxworth, Gerald M., Columbia (Member Cape Girardeau County Medical Society)
Hoye, Robert C., Farmington
Huang, Chuong Chun, St. Louis
Huang, Jun-Shen, Sikeston
Hubbard, Sally L., Springfield
Hubbell, Ira G., Columbia
Huber, K. Herbert, Livermore, Calif. (Member Lafayette-Ray County Medical Society)
Huber, Lasley E., Moberly
Huck, Frank F., Fenton
Huck, Richard F., St. Louis
Huckstep, Robert A., Farmington
Huddleston, Harvey T., Smithville
Hudgens, Richard W., St. Louis
Hudson, G. R., Moberly
Hueser, James N., Columbia
Huewe, Douglas A., Springfield
Huffman, Thomas L., Butler
Huggins, Albert M., St. Louis
Hughes, Derek Dominic, Columbia (Member West Central County Medical Society)
Hughes, Judson M., St. Joseph
Hughes, Michael F., Kansas City
Hughes, Robert G., St. Louis
Hughes, Shelby B., Clinton
Hulbert, Bernard, St. Louis
Hulstra, Johannes F. W., Springfield
Hummel, Anton J., St. Louis
Hummel, William C., St. Louis
Humphrey, James, Mound City
Humphreys, Edward T., Boonville
Hungate, Carroll P., Kansas City
Hunkeler, John D., Kansas City
Hunleth, Frank E., St. Louis
Hunt, John L., Poplar Bluff
Hunt, John W., Jr., Farmington
Hunt, Robert S., Cape Girardeau
Hunt, Thomas R., Kansas City
Hunter, Martin P., Kansas City
Huntington, Ione, Mt. Vernon
Hunzicker, Warren J., Kansas City
Huq, Md. Nasrul, Mexico
Hurst, Wilfred W., Joplin
Hurwitt, Frank, Kansas City
Huse, William J., II., Kansas City
Hutchinson, James H., Jr., St. Louis
Hutchinson, William B., St. Louis
Hutto, A. Herman, St. Louis
Hwang, Yung H., Carthage
Hyatt, Robert W., Columbia
Hyde, Lawrence L., Kansas City
Hyman, Anna, St. Louis

I

Ide, Carl H., Columbia
Ide, Lucien W., St. Joseph
Idewu, Olawale O., St. Louis
Imes, Elvin D., Maryville
Ingham, Walton C., Kansas City
Inkley, John J., St. Louis
Inman, Max M., St. Louis
Ippensen, John H., Springfield
Irick, Carl C., N. Fort Myers, Fla. (Member St. Louis County Medical Society)
Irvin, William M., St. Louis
Irvine, John W., Kansas City
Irwig, Fred, Kansas City
Isaac, Anita M., Springfield
Isbell, Charles H., Carthage
Ise, Frank H., N. Kansas City (Member Clay County Medical Society)
Ishida, Yasuo, St. Louis
Islam, Mohammed N., St. Louis
Ittner, George W., Jr., St. Louis
Ivy, Henry B., Springfield
Izmirlian, Grant, St. Louis

J

Jablonski, Raymond C., St. Charles
Jackson, Edward K., Clarksville
Jackson, Haywood R., Kansas City
Jackson, Robert L., Columbia

Jackson, Vernon B., Fulton
Jackson, William R., Maryville
Jacob, Karl A., Jr., St. Louis
Jacob, Walter P., Kansas City
Jacobs, Charles C., St. Louis
Jacobs, Frederick A., St. Louis
Jacobs, Morton, Kansas City
Jacobs, Walter H., Kansas City
Jaeckle, Richard G., St. Louis
Jaeger, Joseph N., Jackson
Jaffe, Bernard M., St. Louis
James, Elizabeth J. P., Columbia
James, Otis E., Jr., Kansas City
James, Ronald C., Columbia
Jameson, James E., Springfield
Janes, Donald R., Kansas City
Janney, James G., Jr., St. Louis
Jansen, Robert, Kansas City
Jarvis, Cathy C., Ballwin
Jaudon, Joseph C., St. Louis
Jayanandaiah, H. P., Hannibal
Jean, J. Ted, St. Louis
Jeans, Virgil, Joplin
Jenab, Morteza, Kansas City
Jennett, James H., Kansas City
Jensen, Joshua E., Florissant
Jick, Sidney, St. Louis
Jimenez, Jose, St. Joseph
Jobe, Charles L., Jr., Springfield
Joffe, William S., St. Louis
Johnsgard, Larry S., Columbia
Johnson, C. Laurence, Kansas City
Johnson, Charles Julius, St. Louis
Johnson, Charles S., Warrensburg
Johnson, Dallas A., Kansas City
Johnson, Earl W., Cape Girardeau
Johnson, Ernest D., Cape Girardeau
Johnson, Fritz M., Springfield
Johnson, Gareth R. P., Kansas City
Johnson, George A., Springfield
Johnson, James S., Kansas City
Johnson, Joseph C., Jr., Springfield
Johnson, Joseph E., Kansas City
Johnson, Mitchell D., Ferguson
Johnson, Richard E., Columbia
Johnson, Richard L., Kansas City
Johnson, Roy, Ferguson
Johnson, Thomas M., Kansas City
Johnson, Warford B., Springfield
Johnson, William F., Springfield
Johnston, Glen P., St. Louis
Johnston, Joseph L., Springfield
Johnstone, John, Jr., Kirkwood
Jolly, Benjamin N., Mexico
Jolly, William H., Mexico
Jonas, Harry S., Jr., Independence
Jones, Andrew B., Soddy, Tenn. (Member St. Louis Medical Society)
Jones, Augustin, St. Louis
Jones, David N., Cape Girardeau
Jones, Dorothy J., St. Louis
Jones, Edna M., Clinton
Jones, Edward S., Harrisonville
Jones, Gale O., Kansas City
Jones, Grey, Eminence
Jones, Harold L., Springfield
Jones, James D. II, St. Louis
Jones, James H., St. Louis
Jones, Keith D., Warrensburg
Jones, Marion E., Kansas City
Jones, Otey S., St. Louis
Jones, Richard A., St. Louis
Jones, Samuel T., III, Kansas City
Jones, Sarah T., St. Louis
Jones, Theodore R., Kansas City
Jones, Victor, Brentwood
Jones, Vincent L., St. Louis
Jordan, Walter R., Grapeland, Tex. (Member St. Louis Medical Society)
Joseph, Donald J., Columbia
Joseph, Harold J., St. Louis
Joslyn, Harold L., St. Louis
Jost, Charles A., Florissant
Jotte, Richard F., St. Ann
Judd, Donald, St. Louis
Judge, Walter T., Crystal City
Judy, Joseph D., Florissant
Juergens, William G., St. Louis
Julien, Rene, St. Louis
Jung, J. Marshall, Illmo
Justus, John B., Kansas City

K

Kabir, Mohammed A., St. Louis
Kahler, Monte R., Bolivar
Kahn, Lawrence, St. Louis
Kahn, Marvin, Kansas City
Kairuz, Bartholome C., St. Louis
Kaiser, George C., St. Louis
Kallenbach, Glen P., Mexico
Kamada, Tsutomu, O'Fallon
Kamakas, Nicholas, Florissant
Kamenetzky, Stephen A., St. Louis
Kaminski, Donald L., St. Louis
Kaminsky, Watson W., St. Louis
Kamuran, Ozgoncu, St. Louis
Kanagawa, Harold K., Jefferson City
Kanarek, Joseph, Kansas City
Kandt, Ray E., Jr., Kansas City
Kane, Clyde E., St. Louis
Kang, Chang H., De Soto
Kang, Juan, St. Louis
Kannegiesser, Hartmut, St. Louis
Kantor, Julius M., Kansas City
Kantor, Samuel, Kansas City
Kao, Ming-Shian, St. Louis
Kaplan, Alex H., St. Louis
Kappesser, Netajean B., St. Louis
Kappesser, Roland C., St. Louis
Karandjeff, Apostle D., St. Louis
Karatela, Mohammed, St. Louis
Kardesch, Milton, St. Louis
Karl, Michael M., St. Louis
Karraker, Alvan G., Farmington
Karsh, Robert S., St. Louis
Kartus, Irving, Kansas City
Kaskie, Clifford R., St. Ann
Kasten, Melvin C., Cape Girardeau
Katf, Nicola, Kansas City
Kauffman, Ruth, Versailles
Kaufman, Andrew B., Kansas City
Kaufman, Robert L., St. Louis
Kaufmann, Herbert H., Kansas City
Kaul, Philip G., Kansas City
Kaup, Chandra S., Ballwin
Kay, Billy F., Kansas City
Kayanan, Jose C., Kansas City
Kayes, Jack, St. Louis
Kays, Kenneth M., Columbia
Keeble, Charles B., St. Louis
Keefe, David M., St. Charles
Keeler, James E., Kansas City
Keenoy, John J., St. Louis
Keffler, Karl L., St. Louis
Keim, John H., Cape Girardeau
Keitzer, Walter Ford, Columbia
Keller, David W., St. Louis
Keller, Louis, St. Louis
Keller, Maurice J., St. Louis
Keller, Robert M., Wentzville
Kellett, John G., Webster Groves
Kelley, Gilbert B., Savannah
Kelley, Kenneth H., Poplar Bluff
Kelley, Robert W., St. Louis
Kelling, Douglas G., Overland Park, Kan. (Member Jackson County Medical Society)
Kelling, Jordan, Waverly
Kelly, John J., St. Louis
Kelly, Joseph G., Kansas City
Kelly, Marshall W., Jefferson City
Kelly, R. Emmet, St. Louis
Kelsey, Kenneth L., Aurora
Keltner, R. M., Jr., St. Louis
Keltner, R. O., Shawnee Mission, Kans. (Member Jackson County Medical Society)
Kendall, Charles A., Kansas City
Kendall, Forrest H., Prairie Village, Kan. (Member Jackson County Medical Society)
Kendig, John H., St. Louis
Kendis, Joseph B., St. Louis
Kennard, George K., Kansas City
Kenney, John D., St. Louis
Kenney, Roy E., Neosho
Kent, Bela K., Kansas City
Keown, Kenneth K., Columbia
Kernodle, Jefferson D., Kansas City
Kerr, David N., St. Louis
Kerr, Frank T., Monett
Kerr, S. Earl, Columbia
Kessler, Sheldon, Florissant
Ketterman, Grace H., Kansas City
Ketterman, Herbert L., Kansas City
Kettner, Edward G., Kansas City
Key, James S., Springfield
Key, Martin L., Ste. Genevieve
Keyes, Edward L., Clayton
Khan, Abdul G., Arnold
Khan, Altaf Ali, St. Louis
Khan, Chung H., Waterloo, Ill. (Member St. Louis County Medical Society)
Khan, M. Osman, Maryville
Khodadoust, Kavous, St. Louis
Kieber, Robert W., St. Joseph
Kieffer, Victor B., Jr., Kirkwood
Kielar, Richard A., Fort Leonard Wood
Kiene, Richard H., Kansas City
Kienzle, Edward C., St. Louis
Kilburn, Kaye H., Columbia
Kilker, Clarence H., Normandy
Kilker, Donald E., Normandy
Killen, Duncan A., Kansas City
Kilo, Charles, St. Louis
Kim, Chung Ki, St. Louis
Kim, Hea Ill, St. Louis
Kim, Tchang Man, Columbia
Kimball, Ireland W., Kansas City
Kimball, Merritt H., Kansas City
Kimberlin, Herbert C., Trenton
Kimble, Harvey S., Kansas City
Kimelman, Nathan, St. Louis
Kinder, James A., Cape Girardeau
Kinder, Jerry L., Cape Girardeau
Kindred, Lynn H., Kansas City
King, Elbert R., Boise, Idaho (Member West Central Missouri Medical Society
King, Eustace E., III, St. Louis
King, Francis C., Kirkwood
King, J. Tenbrook, Kansas City
King, James P., St. Louis
King, John V., Jr., DesPeres (Member St. Louis Medical Society)
King, John V., St. Louis
King, Morris K., St. Louis
King, Phillip E., Liberty
King, Richard H., Clinton
King, Robert J., Columbia
King, Walter R., Kansas City
Kingsbury, Helen, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Kingsbury, Robert J., St. Charles
Kingsland, Robert C., St. Louis
Kinney, Sam E., St. Louis
Kinsella, Edward D., Richmond Heights
Kinsella, Peter W., St. Louis
Kinsella, Ralph A., Jr., St. Louis
Kinzie, Jeannie J., Shorewood, Wis. (Member St. Louis Medical Society)
Kinzie, Joseph L., Jr., St. Louis
Kipter, Robert E., Pontiac, Ill. (Member Greene County Medical Society)
Kipnis, David M., St. Louis
Kirkland, Jerry A., Kansas City
Kirkman, Robert E., Joplin
Kirstein, Melvin B., St. Louis
Kissane, John M., St. Louis
Kister, George E., St. Charles
Kistler, Walter D., Jr., St. Louis
Kistner, William F., St. Louis
Kitchen, William M., Kansas City
Klaus, Hanna, St. Louis
Klebba, Larry B., Jefferson City
Klein, Arnold G., St. Louis
Klein, Bert H., St. Louis
Klein, Edward H., Prairie Village, Kan. (Member Jackson County Medical Society)
Klein, Saul J., St. Louis
Kleinschmidt, Clinton, St. Louis
Klenk, Charles L., St. Louis
Kline, Carlyn M., St. Joseph
Kline, Edmund W., St. Joseph
Klingner, George M., Springfield
Klingner, George M., Jr., Springfield
Klinkerfuss, George H., St. Louis
Klippel, Allen P., St. Louis
Klippel, Bernhardt W., St. Louis
Kloecker, Richard J., St. Ann
Kloecker, Robert P., St. Louis
Knabb, Kenneth E., Springfield
Kneal, E. Ellsworth, St. Louis
Kneibert, Fred L., Poplar Bluff
Knepper, Paul A., St. Joseph
Knight, Franklin P., St. Louis
Knight, Lyle B., Lee's Summit
Knight, William A., Jr., St. Louis
Knipschild, Bedford F., Marshall
Knoch, H. Kermit, Kansas City
Knock, Henry L., Kirkwood
Knowles, R. R., St. Louis
Knowlton, Norman P., Jr., St. Louis
Koch, Robert E., Clayton
Kodner, Ira J., St. Louis
Koehler, George A., St. Louis
Koehler, John W., Joplin
Koenig, Marvin I., Florissant
Koerner, Kenneth A., St. Louis
Koessel, Arthur W., St. Louis
Kohler, Louis H., St. Louis
Koldys, Kenneth W., Cape Girardeau
Kolker, Allan E., St. Louis
Kolodny, Robert C., St. Louis
Kolze, Vernon W., Springfield
Komanetsky, William M., St. Louis
Konzelmann, John A., St. Louis
Koon, Ben H., Bolivar
Koontz, Paul G., Kansas City
Kopman, Ercument A., St. Louis
Kopp, Jules H., St. Louis
Kopp, Leonard J., St. Louis
Koppenbrink, Walter E., Jr., Higginsville
Koppers, Lawrence E., Kansas City
Kopta, Joseph A., Oklahoma City, Okla. (Member St. Louis Medical Society)
Korenblat, Phillip E., St. Louis
Korn, Robert L., Clayton
Korth, William M., Sarasota, Fla. (Member Jackson County Medical Society)

Kostianovsky, Jorge E., St. Louis
Kotner, Lawrence M., University City
Kovac, S. Robert, St. Louis
Kowert, Edward H., St. Louis
Kozal, Francis L., Crystal City
Kozlowski, Albert E., St. Louis
Kraeger, Russell, Fort Sill, Okla. (Member St. Louis Medical Society)
Kraft, Jacob, Kansas City
Krahn, Henry C., Springfield
Kramolowsky, Helmuth H., St. Louis
Kraner, Justin F., University City
Kranson, Seymour J., Independence
Kratz, Paul E., Cape Girardeau
Krause, G. Lynn, Jr., St. Louis
Krebs, Joseph M., St. Louis
Kroeger, George B., Jr., St. Louis
Krojanker, Rolf, St. Louis
Kromer, Charles, St. Louis
Kronemer, Norton S., St. Louis
Kruse, Carl R., Palmyra
Kubin, Milford T., Pacific Grove, Calif. (Member Boone County Medical Society)
Kuczer, Arnoldo, St. Louis
Kuebrich, Thomas C., Ferguson
Kuenzi, Donald E., Kansas City (Member Clay County Medical Society)
Kuhlman, Ralph, St. Louis
Kuhlman, Robert E., St. Louis
Kuhn, John R., Jr., Joplin
Kuhn, Nobuko O., St. Louis
Kuhn, William F., II, Kansas City
Kulak, Gary, St. Louis
Kulkamthorn, S., St. Louis
Kulowski, Jacob, St. Joseph
Kunawongsa, Nit, St. Louis
Kunz, Harold G., Jr., St. Louis
Kurtz, Karl J., Kansas City
Kuruvilla, George, Blue Springs
Kusama, Haruo, St. Louis
Kutryb, Walter J., Florissant
Kuttner, Marianne, St. Louis
Kwan, Vincente W., Potosi (Member St. Louis County Medical Society)
Kyger, John E., Independence

L

Laatsch, Robert H., Poplar Bluff
Lachance, Leopold, Centralia
Lacson, Leticia D., St. Louis
Lacy, Paul E., St. Louis
Ladd, Charles B., St. Louis
Ladenson, Roland P., Columbia
LaDriere, Raymond J., Creve Coeur
Ladyman, George H., Poplar Bluff
LaFerriere, Keith A., St. Louis
LaHue, William C., Lexington
Laird, John M., Jr., Florissant
Lally, James J., Kansas City
Lam, Ernesto S., St. Louis
Lam, Robert L., St. Louis
Lamar, Robert F., Kansas City
Lamb, Wanda, St. Louis
Lambert, Marian, Kansas City
Lambie, Rodger W., Kansas City
Lamy, John E., Sedalia
Landau, William M., St. Louis
Landers, Burnell, Kansas City
Landhuis, L. R., Columbia
Landis, George K., Kansas City
Landry, J. Hubert, St. Louis
Lane, Clinton W., St. Louis
Lane, Daniel K., St. Louis
Lang, John J., St. Louis
Lange, Adolph C., St. Louis
Langeluttig, Harry V., El Dorado Springs
Langenbach, Alfred M., Ladue
Langevin, Jack, West Plains
Langlois, Paul J., St. Louis
Langston, Walter R., Springfield
Lanier, Earl W., St. Louis
Lankford, Harold D., Mexico
Lanning, R. James, N. Kansas City (Member Clay County Medical Society)
Lanning, Richard C., Ste. Genevieve
Lanning, Robert J., Hannibal
Lansangan, Isais, Arnold
Lansche, Elmer A., St. Louis
Lansche, W. Edward, St. Louis
Lapi, Angelo, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Lapp, Harry C., Kansas City
Larocca, Felix E. F., St. Louis
Larsen, Kenneth V., St. Louis
Larsen, Virginia, St. Louis
Larson, Paul U., St. Louis
Lassar, Gilbert N., St. Louis
Latham, Kenyon S., California
Latham, Raymond W., Kansas City
Latimer, Walter N. A., Kansas City (Member Clay County Medical Society)
Lattinville, Henry E., Florissant
Lau, Luis, St. Louis
Lauber, Joseph J., St. Louis
Lauer, Daniel J., Kansas City
Lauer, John D., St. Louis
Laux, France A., St. Louis
Lawrence, George H., St. Louis
Lawrence, John R., Marshall
Lawton, John T., St. Louis
Lawton, Lawrence M., St. Louis
Layle, John K., Jr., Kansas City
Layton, Ira C., Kansas City
Leach, Wilfred, St. Louis
LeBlanc, Leo J., St. Louis
L'Ecuyer, Jerome L., St. Louis
Lederer, Charles M., Warrensburg
Lee, Carleton H., St. Joseph
Lee, Duk S., St. Louis
Lee, Fransiska, St. Louis
Lee, Gerald B., Kansas City
Lee, Henry A., Kansas City
Lee, King Ying, Kansas City
Lee, Sung Ae, Columbia
Lee, Tae Hung, Kansas City
Lee, Yeu-Tsu, Los Angeles, Calif. (Member Boone County Medical Society)
Leech, Charles A., Columbia
Leech, Maurice P., Fayette
Leeper, Sidlee W., Columbia
Le Fevre, Philip J., Springfield
Legan, John K., Kennett
Lehman, Philip C., St. Joseph
Lehner, Richard L., Kansas City
Lehr, James L., Columbia
Leidinger, Karl J., Republic
Leifer, William W., Kansas City
Leightner, William, St. Louis
Leitch, Cecil G., Blue Springs
Lembeck, Joseph A., St. Louis
Lemmon, George B., Springfield
Lenobel, Milton I., Clayton
Lentz, Clark H., Kansas City
Lentz, Harold C., Neosho
Leo, William A., Kansas City
Leonhardt, Erwin M., St. Louis
Leonidas, John C., Kansas City
Lepley, Rosalyn, St. Louis
Leroux, Gene H., Doniphan
Lerwick, Everett R., St. Louis
Leslie, Charles H., Kirkwood
Leslie, James T., Jr., Jefferson City
Lestmann, Henry E., Doniphan
Levey, Harry B., Kansas City
Levin, Marvin E., St. Louis
Levitt, Joseph, St. Louis
Levy, Irwin, St. Louis
Levy, Jerome F., St. Louis
Levy, Morton A., University City
Lewellen, Charles H., Louisiana
Lewin, Wilbur H., St. Louis
Lewis, Charles R., Florissant
Lewis, James E., Jr., St. Louis
Lewis, Noel R., Springfield
Lewis, Ray B., Rocheport
Lewis, Revis C., Kansas City
Leydig, Stanley M., St. Louis
Liang, Howard S., St. Louis
Liang, Jing C., Independence
Liao, Kun T., St. Louis
Lichtor, Alexander, Kansas City
Lichtor, Joseph M., Kansas City
Lichty, Charles A., Shelbina
Lieb, Francis X., St. Louis
Lieb, Otto, St. Louis
Lieberman, David M., St. Louis
Liese, Grover B., St. Louis
Lila, Aram, Excelsior Springs
Lillard, Stephen B., Columbia
Lilly, Douglas R., St. Louis
Lim, Jet Kim, Columbia
Limpatakmonkol, P., Manchester
Lincoln, James, Troy
Lindberg, Donald, Columbia
Lindeman, Carl H., St. Louis
Lindeman, John, St. Louis
Linder, Howard E., St. Louis
Lindgren, Carleton J., Kansas City
Lindquist, Carl N., Reeds Spring (Member Jackson County Medical Society)
Link, Alexander J., St. Louis
Link, Vance E., Independence
Lins, Robert D., Des Peres
Linsenmeyer, Charles M., St. Charles
Linville, Howard E., Kansas City
Lipschitz, Ervin, St. Louis
Lipsitz, Ellis S., St. Louis
Lischer, Carl E., St. Louis
Liss, Jay Lawrence, St. Louis
Lissner, Arthur B., O'Fallon
Little, Monroe H., St. Louis
Littlejohn, Robert T., N. Kansas City
Littmann, Lewis E., St. Louis
Litton, Lyle D., Springfield
Litwiller, R. W., Columbia
Litzow, Louis T., St. Louis
Liu, Paul I., Kansas City (Member St. Louis Medical Society)
Livingston, Don, St. Louis
Lloyd, Ivan E., Kansas City
Lockhart, Charles E., Springfield
Lodwick, Gwilym S., Columbia
Loeb, Richard H., Springfield
Loeb, Virgil, Jr., St. Louis
Loeffel, Ellen S., St. Louis
Logie, MacDonald B., St. Louis
Logue, John T., Columbia
Lohmar, Roland E., Columbia
Lohr, Robert W., St. Louis
Lohrentz, Lois H., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Loitman, Bernard, St. Louis
Londe, Alan M., St. Louis
Londe, Sol, St. Louis
London, Stanley L., St. Louis
Lonergan, Warren M., St. Louis
Long, Curtis W., Butler
Long, David S., Harrisonville
Long, Frank B., St. Louis
Long, R. Stacy, Kansas City
Longenecker, Joe L., Joplin
Lonsway, Maurice J., St. Louis
Lonsway, Maurice J., Jr., St. Louis
Lopez-Plata, Roberto, Kansas City
LoPiccolo, Vincent J., St. Louis
LoPiccolo, Vincent J., Jr., St. Louis
Lord, Richard E., Kirkwood
Lorenc, Ernest, Springfield
Lorenzo, Edilberto B., Kansas City
Lotito, Carlos A., Kansas City
Lottes, James O., St. Louis
Loughead, John R., Poplar Bluff
Loutzenhiser, James K., Kansas City
Lovett, Robert L., Springfield
Lovinggood, Thomas A., Cape Girardeau
Lowe, Alvin L., Sedalia
Lowe, Horace A., Jr., Springfield
Lowell, Paul, Kansas City
Lowenstein, Paul S., St. Louis
Lowther, Gerald S., Chesterfield
Loyd, Earl L., Holts Summit (Member Cole County Medical Society)
Lucas, Fred V., Columbia
Lucas, G. Elden, St. Louis
Lucido, Joseph L., St. Louis
Luckenbill, Paul T., Plattsburg
Luechtefeld, Frank, St. Joseph
Luedde, Philip S., St. Louis
Luehrs, Robert O., St. Louis
Lugo, Samuel, St. Louis
Luh, Andrew, St. Louis
Lum, Jon Tek, St. Louis
Lund, Herluf G., St. Louis
Lund, Robert H., Clayton
Lundgren, Fred H., Jr., Kansas City
Lurie, Harold H., Springfield
Lusk, Charles A., Jr., Butler
Luther, George A., Kirkwood
Lutkewitte, Joseph F., Ste. Genevieve
Lutz, Martin H., St. Louis
Lyddon, Harold R., Jr., Kansas City
Lyle, Robert R., Versailles
Lyman, Edward H., St. Louis
Lynxwiler, Chester P., St. Louis
Lyskowski, Maria, St. Louis
Lyss, Carl, St. Louis
Lyss, Stanley B., University City
Lyttle, Garnet C., St. Louis
Lytton, George J., Kansas City

Mc

McAdam, Charles R., St. Louis
McAfee, C. Alan, St. Louis
McAfee, R. Gordon, Kansas City
McAlhany, Howard J., Springfield
McAlister, William H., St. Louis
McArtor, Thomas R., Browning
McBurney, Charles A., Slater
McCaffree, Mary K., Jefferson City
McCall, Edwin L., Kimberling City
McCalla, John P., Kansas City
McCallister, Ben D., Kansas City
McCann, Louis P., Nevada
McCanse, Andrew, Kansas City
McCarroll, H. Relton, Jr., St. Louis
McCarthy, John M., St. Louis
McCarthy, Thomas D., Ferguson
McCaughan, John M., St. Louis
McClanahan, Robert C., Kansas City
McClelland, Bruce A., Columbia
McCloskey, R. Bruce, St. Louis
McCluer, Shirley, Columbia
McCluggage, Newton C., Kansas City (Member Clay County Medical Society)
McClure, David N., St. Louis
McClure, James N., Jr., St. Louis
McConahay, David R., Kansas City

McConchie, James E., Independence
McConnell, Robert G., Manchester
McCool, James F., Jr., St. Louis
McCool, Stanley G., St. Louis
McCord, E. Scott, Columbia
McCorkle, E. Lee, Marshall
McCormick, James E., Kansas City
McCown, Allan H., Kirkwood
McCoy, Frederick J., Kansas City
McCoy, Warren R., Caruthersville
McCraw, Doyle C., Bolivar
McCray, Glen M., Kansas City
McCullough, Campbell C., Kansas City
McDaniel, John R., St. Joseph
McDermott, Alfred E., Perryville
McDonald, Eugene F., Jackson
McDonald, Herbert L., Kansas City
McDonald, Wallace, St. Joseph
McDonald, Wilbur P., St. Joseph
McDonnell, John F., Kansas City
McDonough, John, St. Louis
McDowell, Richard L., St. Louis
McElroy, Glenn L., Columbia
McEnery, Joseph P., St. Louis
McFadden, Gene A., Waverly
McFadden, James F., Sr., St. Louis
McFarland, H. Richard, Kansas City
McFarland, Morris D., Kansas City
McGannon, Paul T., Kansas City
McGinnis, Byron J., St. Louis
McGinnis, William F., St. Louis
McGinty, Charles P., Cape Girardeau
McGonigle, James P., Joplin
McGuire, Thomas H., Kansas City
McHaney, John W., Jefferson City
McIntosh, Donald E., Kansas City
McIntyre, John D., Kansas City
McKaskle, Clarence W., Caruthersville
McKee, Howard B., Joplin
McKee, Oliver A., Kirkwood
McKee, Wallace P., Kansas City
McKeel, Thomas B., Kansas City
McKinney, Joseph K., St. Louis
McKinsey, John J., Springfield
McKnelly, William V., Jr., Kansas City
McLane. Jerry F., Poplar Bluff
McLaughlin, Kathleen, St. Louis
McLaughlin, Richard D., Springfield
McLean, Harry A., St. Louis
McLean, Royal C., St. Louis
McLeod, John, Kansas City
McMillan, Thomas E., Kansas City
McMurray, Herhert C., Manchester
McNabney, W. Kendall, Kansas City
McNalley, Michael, St. Louis
McNamara, John J., Richmond Heights
McNeel, Lee A., Jr., Greenfield
McNutt, Theodore L., Kansas City
McPhee, William R., Kansas City
McPheeters, James W., Poplar Bluff
McPike, Lloyd H., Joplin
McQueen, Samuel, St. Louis
McSwiney, John G., St. Louis
McVay, James R., Kansas City
McWherter, Lottie B., Shawnee Mission, Kan.
(Member Jackson County Medical Society)

M

Maben, Sam Edward, Kansas City
Macauley, Bernard J., Poplar Bluff
MacDonald, Robert R., Jr., St. Louis
Macdonald. William C., St. Louis
Macdonnell, Thomas M., Marshfield
MacGee, Edwin E., Kansas City
Machek, Otakar, St. Louis
MacInnis. Florence E., Kansas City
MacLaughlin, James C., Joplin
Macleod, Angus. St. Louis
MacNaughton, Ralph E., Kansas City
MacNaughton, Robert A., Leawood, Kan.
(Member Jackson County Medical Society)
Macnish, James M., St. Louis
Maddox, Albert R., Sedalia
Maddux, William P., Springfield
Madrid, Dominador, St. Louis
Magaletta, George E., Cape Girardeau
Magee, Robert L., El Dorado Springs
Magee, William E., St. Louis
Magill, Joseph S., Milan
Maginn, R. Reilly, St. Louis
Maginn, Richard L., St. Joseph
Magness, Guy N., University City
Magness, William C., Branson
Magruder, L. M., Nevada
Mahboubi, Aziz Olla, Sikeston
Mahe, George A., St. Louis
Maher, Robert W., Springfield
Maher, Thomas F., St. Louis
Maizus, Saul H., St. Louis
Mallouk, Alexander G., Kansas City
Maloney, Robert M., St. Louis
Malt, Sherwin H., Creve Coeur
Maminta, Napoleon S., Chesterfield
Manalo, Gil B., Jr., Carthage (Member Jefferson County Medical Society)
Manansala, Antonio Q., St. Louis
Mandler, George, Chillicothe
Manes, Jose, St. Louis
Manganaro, Frank J., St. Louis
Mangels, Kenneth A., Independence
Mangelsdorf, Thomas K., St. Louis
Manion, Peter J., St. Louis
Manley, Charles B., Jr., St. Louis
Mann, James K., Hannibal
Manske, Paul R., St. Louis
Mantell, Jack M., Springfield
Manuel, Louis C., Kansas City
Maple, Francis M., Springfield
Maranan, D. L., Kirkwood
Maravilla, Levy M., St. Louis
Marban, Manuel I., St. Louis
Marco, Philip J., Columbia
Marcus, Morris D., St. Louis
Mardini, Edward E., Bonne Terre
Margolis, Richard M., St. Louis
Marienfeld, Carl J., Columbia
Markel, Arthur D., Poplar Bluff
Marks, Mark M., Kansas City
Marmor, William A., St. Louis
Mars, Hartley F., Forsyth
Marsh, Alice, Pleasant Hill
Marshall, Cameron F., Shawnee Mission, Kan.
(Member Jackson County Medical Society)
Marshall, Hal E., Kansas City
Marshall, William G., Glasgow
Marston. F. James, Jr., St. Joseph
Martel, Dominique, St. Louis
Martin, Andrew D., Sikeston
Martin, Clarence A., Joplin
Martin, Clyde V., Kansas City
Martin, Daniel J., St. Louis
Martin, Forrest L., Nevada
Martin, Frederick W., Jr., St. Louis
Martin, J. Barlow, St. Louis
Martin, James M., St. Louis
Martin, John N., St. Joseph
Martin, Thomas F., Granite City, Ill.
(Memher St. Louis Medical Society)
Martin, W. Joe, Louisiana
Martz, Bill L., Kansas City
Martz, John C., St. Louis
Mason, Wayne E., Kansas City
Massie, Edward, St. Louis
Masters, Edwin J., Advance
Masters, William H., St. Louis
Masterson, Byron J., Kansas City
Masucci, Joseph M., Kansas City
Mathew, M. S., Chesterfield
Mathews, Robert, Kansas City
Matteson, Frank B., Grant City
Matthews, John G., St. Louis
Matthews, John I., Jefferson City
Mattis, Robert D., Clayton
Mauch, E. Jane, Nevada
Maughs, Sydney B., St. Louis
Max, Paul F., St. Louis
Maxey, Hugh W., Jefferson City
Maxson. T. Reed. Warrensburg
Maxwell, Richard W.. St. Louis
May, Albert L.. Jr., Poplar Bluff
May, Mark, Pittsburgh, Pa. (Member St. Louis Medical Society)
Mayer, John H., Jr., Kansas City
Mayer, John H., III, Kansas City
Mayer, Robert A.. St. Louis
Mayer. William D., Columbia
Mayfield, James L.. Crystal City
Mays, Frank G.. Washington
Mayuga, Edgardo, St. Louis
Mayuga, Laureano G., Cabool
Meador. James B., St. Louis
Meadows, C. Douglas, St. Louis
Medina-Lorenzo, Remedios, Kansas City
Medler, Francis J., St. Louis
Medler, John F., St. Louis
Medler, P. Louis, Florissant
Medlicott, William J., Kansas City
Medrano, Crescenciano A., St. Louis
Medrano, Lina Ebro. St. Louis
Meegan, Robert J., Kansas City
Mehan, Donald J.. St. Louis
Mehra, Ravinder B., St. Louis
Mehra, Usha, St. Louis
Mehta, Satish K., Kansas City
Meier, Francis X., Jefferson City
Meinberg. William H.. St. Louis
Meiners, Paul N., St. Louis
Meiners. Theodore M., St. Louis
Meinershagen, Charles W., Jefferson City
Mejia, Hugo, St. Louis
Melgaard, S. Ross, Kansas City
Melick. William F., St. Louis
Mell, Roger L., St. Louis
Melson, G. Leland, St. Louis
Menchetti, Don E., Springfield
Mencias, Cristeta B., St. Louis
Mendelsohn, Robert S., St. Louis
Mendelson, David F., St. Louis
Mendez, Manuel M., St. Louis
Menendez, Manuel F., Ballwin
Menendez, Silvana, Ballwin
Mendonsa, Lawrence E., St. Louis
Meneses, Orlando G., St. Louis
Menne, Marvin G., Ironton
Mentgen, Carl N., Springfield
Merenda, Sam J., St. Louis
Merideth, Mary Jane, Cassville
Meriwether, Don R., Mission, Kan.
(Member Jackson County Medical Society)
Merrims, Theodore, St. Louis
Merritt, Burch A., St. Louis
Merveille, Octave C., Kansas City
Merz, Jean J., Creve Coeur
Mestres, Hugh M., St. Louis
Metz, Charles O., St. Louis
Metzgar, Marshall T., Columbia
Metzl, Kurt, Kansas City
Meyer, Herman M., University City
Meyer, James E., Manchester
Meyer, Jay, Clayton
Meyer, Jerry L., Concordia
Meyer, John S., St. Louis
Meyer, Melvin E., St. Louis
Meyer, Paul W., Kansas City
Meyers, David S., Columbia
Meyers, Elsie F., St. Louis
Meyers, Harold L.. Kansas City
Meyers, Jerry, St. Louis
Meyers, John B., Clayton
Meyers, Robert W., St. Louis
Mezera, Raymond A., St. Louis
Michael, Harvey R., Springfield
Michael, Kenneth D., St. Louis
Michael, Vernon E., St. Louis
Michaelree, John F., St. Louis
Miciano, Ruel T., Oak Grove
Middleton, Jerry N., St. Louis
Middleton, John W., Louisiana
Mier, Thomas M., St. Louis
Milder, Benjamin, St. Louis
Miles, George O., Kansas City
Miles, Glenn E., Louisiana
Miles, Paul W., St. Louis
Milgram. Byron A., Kansas City
Mill, William B., Jr., St. Louis
Millangue, Consolacion P., Rock Hill
Millangue, Rafael M., Rock Hill
Miller, Arthur N., Kansas City
Miller, Charles, Jr., Kirkwood
Miller, Clinton L.. Lee's Summit
Miller, Clyde S.. Waynesville
Miller, D. Herbert, Tulsa, Okla. (Member Chariton-Macon-Monroe-Randolph County Medical Society)
Miller, David V., Poplar Bluff
Miller, Edward J.. St. Louis
Miller, Geoffrey W., St. Louis
Miller, Gerald L., Kansas City
Miller, James E., St. Louis
Miller, James R.. St. Louis
Miller, Jule P., Jr.. St. Louis
Miller. Leroy J.. Columbia
Miller, Max I., Kansas City
Miller, Norman C., St. Louis
Miller, Richard B., St. Charles
Miller, Rohert N.. St. Louis
Miller, William V., St. Louis
Miller. Wilson H., Kansas City
Millikan, Larry E., Columbia
Milne, J. L., Springfield
Milstead. Kenneth L., Jr., St. Louis
Milster, Clyde R.. St. Louis
Miltenberger, Paul C.. Kennett
Minnigerode, Turner L., Kansas City
Minnihan, Robert W.. Chesterfield
Minton, Robert S., St. Joseph
Mirbaha. Mitchell M.. St. Louis
Mishkin, Marvin R., St. Louis
Miskovsky. Emil F., St. Louis
Missey. Wilburn C., Jr.. St. Louis
Mitchell, Andrew D., Kansas City
Mitchell, Eugene, St. Louis
Mitchell, Franklin L., Columbia
Mitchell, John D., Kansas City
Mitchell, Lynn D., Columbia
Mitchell, Robert H., Kansas City
Mitchell, Roy E., Salem
Mitchell. Thomas J., St. Clair
Mitra, Nirmal K., Kansas City
Mixson. William C.. Kansas City
Moallempour, Issa, St. Louis
Moellenhoff, Robert W., Washington
Moen, Berwyn H.. St. Joseph
Molden, Charles A., St. Louis
Monafo. William W., Jr., St. Louis
Monat, Seymour. St. Louis
Monroe. C. Dean, Columbia
Monta, Mande D., St. Joseph
Montani, Charles, St. Louis

Montellano, Arturo H., Monett
Montello, Samuel A., Kansas City
Montes, Arturo C., St. Louis
Montes-de-Oca, Julio, St. Louis
Montgomery, Austin F., St. Louis
Montie, Joseph E., Columbia
Moolsintong, P., St. Louis
Moon, Thomas R., Jr., St. Louis
Mooney, Justin L., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Mooney, Marcel L., Kansas City
Moore, Alva, St. Louis
Moore, De Armond, Springfield
Moore, Harry G., St. Louis
Moore, Harry G., Jr., St. Louis
Moore, Robert A., Kansas City
Moore, Walter L., St. Louis
Moran, Thomas M., St. Louis
Moranville, Benedict A., Columbia
Moreano, Armando H., Kansas City
Morehead, William E., Malden
Morest, F. Stanley, Springfield (Member Jackson County Medical Society)
Morgan, David B., Kansas City
Morgan, Harry C., St. Louis
Morgan, Marvin W., Poplar Bluff
Morgan, Philip E., Columbia
Morgan, Stephan S., St. Louis
Morgan, Troy O., Jr., Albany
Morgan, W. Thomas, Jr., West Plains
Morgan, William R., Kansas City
Moritz, Gerald W., St. Louis
Morley, Louise A., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Morrin, Kevin C., St. Louis
Morris, Alan H., St. Louis
Morris, Harvey E., St. Louis
Morris, Joseph H., Jr., Kansas City
Morris, Mary E., St. Louis
Morris, R. William, St. Louis
Morrison, Arlen, St. Louis
Morrison, Donald H., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Morrison, J. Scott, Kansas City
Morrison, T. A., Aurora
Morse, John P., St. Joseph
Morse, Marvin, St. Joseph
Mortensen, Frede, St. Louis
Morton, Paul C., Springfield
Mosbacher, Hugh E., Independence
Mosby, Larry Dee, Columbia
Moseley, F. Thomas, Springfield
Moseley, Otis O., Osage Beach
Moses, Robert A., St. Louis
Mosquera, Jaime, Florissant
Moss, Paul, Kansas City
Mosser, Robert S., Overland Park, Kan. (Member Jackson County Medical Society)
Mothershead, John L., St. Joseph
Motzel, Albert J., St. Louis
Mou, Bin, Nevada
Mountjoy, Grace S., St. Louis
Mowrer, Marie O., St. Louis
Mowrey, William O., Jennings
Muckerman, Richard I. C., St. Louis
Mudd, J. Gerard, St. Louis
Muelheims, Gerhard H., St. Louis
Mueller, Adolph R., Jr., Joplin
Mueller, Clarence E., Creve Coeur
Mueller, Joseph A., St. Louis
Mueller, Martin J., Kansas City
Mueller, Morris A., St. Louis
Mueller, Robert, St. Louis
Mueller, Robert J., St. Louis
Mueller, Wilbur K., St. Louis
Muench, Albert H., St. Joseph
Muenster, Vincent P., St. Charles
Muether, Raymond O., St. Louis
Muhm, Harvard Yale, St. Charles
Mullarky, Wilbur A., Chesterfield
Mullen, Jack, Bonne Terre
Mullen, Leo M., Kansas City
Mullican, Charles, St. Joseph
Mulligan, Leo V., St. Louis
Mullinax, Orr, St. Joseph
Mullins, Bernard L., N. Kansas City
Mullins, John E., St. Louis
Mullins, Maurice F., Columbia
Mundy, William L., Kansas City
Murdock, Nathaniel H., St. Louis
Murney, Joseph A., Washington
Muro, F. Del, Kansas City
Murphy, Bernard L., Hannibal
Murphy, George E., St. Louis
Murphy, James J., Kansas City
Murphy, James P., St. Louis
Murphy, John C., St. Louis
Murphy, Michael G., St. Louis
Murphy, Paul, St. Louis
Murphy, Robert J., Kansas City
Murray, Wilber L., Kansas City
Muschany, Norman K., St. Louis
Musgrave, David E., Excelsior Springs
Muth, Robert G., Kansas City
Myers, David W., Jr., Smithville
Myers, Ivan T., St. Louis
Myers, James M., Rolla
Myers, John S., Kansas City
Myers, Robert M., Kansas City

N

Nahm, Chung Chick, St. Louis
Naime, Mansour J., Kansas City
Nakada, James R., St. Louis
Nalagan, Marcos C., St. Louis
Napper, Marvin L., Springfield
Naryka, Joseph J., St. Louis
Nash, Helen E., St. Louis
Nathan, Lester J., St. Louis
Navato, Jose, Manchester
Near, David M., Florissant
Negrete, Abelardo, Kansas City
Nelson, Bentley A., Kansas City
Nelson, J. Roger, Kirkwood
Nelson, James S., Clayton
Nemec, Stanley S., St. Louis
°Nemer, Robert J., Vienna (Member Cole County Medical Society)
Ness, Carl K., St. Joseph
Nesselrode, John H., Independence
Nester, Charles A., St. Louis
Neu, Leo T., Jr., Springfield
Neubeiser, Ben L., St. Charles
Neukom, George B., Farmington
Neumann, James W., Kansas City
Neun, William F., St. Louis
Newcomb, Arthur D., Joplin (Member Mineral Area County Medical Society)
Newman, Percy, St. Louis
Newman, Robert L., Kansas City
Newmark, Leonard N., St. Louis
Newport, Gerald, St. Louis
Newton, Gordon, St. Louis
Newton, William T., St. Louis
Nickel, James F., St. Louis
Nickels, Mathew L., Louisiana
Nickson, Charles E., Jr., Independence
Nicolai, Charles H., St. Louis
Niedermeyer, Edward L., Tarkio
Niedermeyer, George J., St. Louis
Niesen, Frank J., St. Louis
Nieuwenhuizen, Maarten, Columbia
Nieva, Delfin T., St. Louis
Nigh, Charles A., St. Louis
Nigro, E. Robert, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Nigro, Joseph A., Kansas City
Nishi, Toshio, St. Louis
Nixon, Edward E., Gallatin
Noback, Richardson K., Kansas City
Nolan, Charles J., St. Louis
Noller, Henry W., Overland
Nolph, Georgia B., Columbia
Noltensmeyer, Milton N., Kansas City
Nomura, Roy M. Y., St. Louis
Norland, Charles C., St. Louis
Nouhan, Joseph G., Jr., St. Louis
Nouri, Hassan, St. Louis
Novak, Edward J., Kansas City
Nuetzel, John A., St. Louis
Nukrongsin, Somporn, St. Louis
Nunez, Maria M., St. Louis
Nunnelly, Gordon M., Cape Girardeau
Nussbaum, Robert A., St. Louis
Nye, Robert S., St. Louis

O

Oakley, Margaret M., St. Louis
Obando, Francisco J., Troy
O'Bannon, Lon W., Jr., Florissant
Obermeyer, Charles G., St. Louis
O'Brien, Edward C., St. Louis
O'Brien Edward J., St. Louis
O'Brien, Harry F., Mexico
O'Brien, Liam, St. Joseph
O'Brien, Robert M., St. Louis
Oceeno, Victor G., Monett
O'Connor, Robert J., Florissant
O'Connor, William B., St. Joseph
O'Donnell, Joseph V., St. Louis
O'Dowd, James A., St. Louis
Oehler, William F., Cape Girardeau
Oestreich, Alan, Columbia
Oetter, Donald L., St. Louis
O'Farrell, Thomas P., Kansas City
Ogilvie, John H., Gravois Mills
Oglesby, Richard B., St. Louis
Ognyanov, V. F., St. Louis
Ogura, Joseph H., Ladue
O'Hearne, John J., Kansas City
Ohlms, David L., St. Louis
Ohmoto, Masao, St. Louis
Ojascastro, Alejandro C., St. Louis
O'Keefe, Joseph D., St. Louis
O'Kell, Richard T., Kansas City
Okun, Edward, St. Louis
O'Leary, James L., St. Louis
Olive, George C., Neosho
Oliver, George A., Farmington
Olmsted, William H., St. Louis
Olney, John W., St. Louis
Olson, Elbert R., Springfield
Olson, Richard O., Jr., St. Charles
Olson, Robert E., St. Louis
O'Malley, James F., Kansas City
O'Neal, Lawrence W., St. Louis
O'Neal, Patricia, St. Louis
O'Neil, James H., Kansas City
Onken, Henry D., St. Louis
Oppenheimer, Henry E., Clayton
Ordoukhanian, Tatool, St. Charles
O'Reilly, D. Elliott, St. Louis
Orenstein, Joseph M., St. Louis
Orgel, M. Norman, St. Louis
Orgel, Michael, St. Louis
Orsay, Paul K., St. Louis
Orth, Oliver G., Columbia
Ortiguero, Leopoldo M., St. Louis
Ortillo, Amado P., St. Louis
Ortmeyer, Leroy F., St. Louis
Osborne, Jere O., Kansas City
Osbourn, Richard A., Fulton
Ossman, Julian A., Jefferson City
Ost, Mark D., Kansas City
Ostapowicz, Frank, St. Louis
O'Sullivan, Daniel F., St. Louis
O'Sullivan, George A., St. Louis
Ott, F. Thomas, Glendale
Ott, Harold J., II, St. Louis
Ott, Harold J., Maplewood
Ottensmeyer, Charles D., St. Louis
Otto, Thomas G., Cape Girardeau
Ottolini, James L., Creve Coeur
Overend, Donald S., Springfield
Overesch, Harry B., Kansas City
Overholser, Milton D., Columbia
Owen, Robert F., St. Louis
Owens, James L., Kansas City
Owens, John H., Sedalia
Owens, Richard L., Kansas City
Owens, Robert H., Kansas City
Owens, William D., St. Louis
Ozar, Milton B., Kansas City
Ozenberger, Larry A., Plattsburg
Ozmat, Orhan, St. Louis

P

Pack, Gary L., Kansas City
Packman, Robert C., St. Louis
Paddock, Charles S., Joplin
Padilla, Teresita C., St. Louis
Page, Jesse W., Sikeston
Paine, Robert, St. Louis
Painter, Andrew E., Portageville
Painter, Lattie B., Jr., Portageville
Pakula, Sidney, Kansas City
Palagiri, Adiraju, St. Louis
Palazzo, Frank A., St. Louis
Palcheff, Chris L., Springfield
Palenske, Robert L., Hornersville
Paletta, Francis X., St. Louis
Paletta, Theodore L., St. Louis
Palmer, Lily Ann, Webster Groves
Pangilinan, Antonio G., Milwaukee, Wis. (Member St. Louis Medical Society)
Pappalardo, Carlos, St. Louis
Parato, John M., St. Louis
Pardo, Leopoldo P., Jr., St. Louis
Parelman, Allen G., Kansas City
Paris, William H., Normandy
Park, Agatha Lee, St. Louis
Park, Duk Jae, Festus
Park, William I., Jr., Springfield
Parker, Arthur C., Jr., Poplar Bluff
Parker, Hubert M., Kansas City
Parker, Robert H., Kansas City
Parker, Thomas W., University City
Parker, William, St. Louis
Parlato, George S., Springfield
Parsi, Manutchehr K., St. Louis
Parsons, D. LeRoy, Cape Girardeau
Parsons, Eugene O., Stanley, Kan. (Member Jackson County Medical Society)
Parsons, Richard P., St. Louis
Partap, Prabha, St. Louis
Pascoe, James J., Nevada
Pasia, Ebello T., Florissant
Passanante, Bartholomew M., St. Louis
Patrick, Roman L., Jr., St. Louis
Patterson, Donald R., Joplin
Patterson, Grover S., Carthage
Patton, Douglas S., St. Louis
Paul, Paul V., St. Louis
Paulson, Gordon S., St. Joseph
Pavlu, Robert R., Waverly
Pawol, S. E., St. Louis
Pawsat, John E., Kansas City

Payne, David E., Columbia
Payne, John W., Columbia
Payne, Meredith J., St. Louis
Payne, Vaughn C., St. Louis
Pearlman, Alan L., St. Louis
Pearman, Carl C., Columbia
Pearse, Roy W., Jr., Nevada
Pearson, Paul E., Kansas City
Peck, Chester R., Jr., Kennett
Pecoraro, Anthony P., Kansas City
Peden, Burnet W., Clayton
Peden, James C., Jr., St. Louis
Peden, Joseph C., St. Louis
Peden, Joseph C., Jr., St. Louis
Pedersen, Harold J., Ballwin
Peebles, J. B., Jr., Kirkwood
Peete, Don C., Kansas City
Pelegrin, Robert J., Independence
Pelican, George, St. Louis
Pelz, Mort D., St. Louis
Pence, F. Wendell, Carthage
Pendell, Paul W., Rolla
Penilla, Antonio R., St. Louis
Penner, Stanley, Kansas City
Penninger, William H., Springfield
Pennington, Francis E., St. Louis
Pennoyer, James, Webster Groves
Pepper, Edward G., St. Louis
Pepper, Max, St. Louis
Perez, Adamor R., St. Louis
Perez, Blanca M., St. Louis
Perez, Carlos A., St. Louis
Perez, Raul A., St. Louis
Perez, Romulo G., Troy
Perez-Mesa, Carlos, Columbia
Perico, Carlos J., Kansas City
Perkins, David E., St. Louis
Perkoff, Gerald T., St. Louis
Perll, Maurice F., Kansas City
Perll, Rita D., Kansas City
Perna, Vincent P., Creve Coeur (Member St. Charles-Lincoln County Medical Society)
Pernoud, Flavius G., Jr., St. Louis
Pernoud, Michael F., St. Louis
Perry, H. Mitchell, St. Louis
Perry, Ralph, Kansas City
Perry, William D., St. Louis
Petersen, Eugene G., Lee's Summit
Petersen, Harold E., St. Joseph
Peterson, Bonita J., Kansas City
Peterson, Carl M., Kansas City
Peterson, Donald B., Fulton
Peterson, Frederick D., St. Louis
Peterson, George L., Kansas City
Peterson, Milton C., Sun City, Ariz. (Member Jackson County Medical Society)
Peterson, Stanley S., Springfield
Peterson, Vernon J., Columbia
Peterson, Walter R., Kansas City
Petry, Ezra L., Lenexa, Kan. (Member Jackson County Medical Society)
Pfefer, Leland U., Columbia
Pfeffer, Robert I., St. Joseph
Pfeifer, Oliver C., St. Louis
Philip, Varkey, St. Louis
Phillips, Abraham M., St. Louis
Phillips, Granville J., Jr., El Paso, Tex. (Member St. Louis Medical Society)
Phillips, Hanford, St. Louis
Phillips, John J., St. Louis
Phillips, William J., St. Louis
Philpott, Gordon W., St. Louis
Phipatanakul, Supote, St. Louis
Piccione, Leonard N., St. Louis
Pichardo, Javier, Farmington
Pickard, Clarence M., Columbia
Pickard, Nicholas S., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Pickens, E. Allen, Fulton (Member West Central Medical Society)
Pickens, James Milton, Columbia
Piebenga, Larry W., Kansas City
Piepergerdes, Larry G., Kansas City
Pifer, Lawrence H., St. Joseph
Pileggi, Felix A., N. Kansas City
Pilla, Lawrence A., St. Louis
Pimentel, Esperanza, St. Louis
Pineda, Hector O., St. Louis
Pingelton, William B., Columbia
Pinkerton, Joseph A., Jr., Kansas City
Pinkstaff, Thomas H., Sikeston
Pinsker, Oscar T., Kansas City
Pinto, John F., St. Louis
Piper, August T., St. Louis
Piper, Donald K., Kansas City
Pipes, Keith E., St. Louis
Pipkin, Garrett, Clinton (Member Jackson County Medical Society)

Pitsinger, Nolan B., St. Louis
Pittman, Gerald, St. Louis
Pittman, Susan, St. Louis
Pitts, Ferris N., Jr., St. Louis
Pizzimbono, Carlos A., Highland, Ill. (Member St. Louis Medical Society)
Platt, William R., St. Louis
Platz, John H., Carrollton
Plax, Steven, St. Louis
Plesons, John D., St. Louis
Plowman, Edward M., Hannibal
Plumpe, W. Tupper, St. Louis
Plunkett, Littleton J., Jr., Poplar Bluff
Podos, Steven M., St. Louis
Podrecca, Guido I., Springfield
Poggemeier, William H., Jr., St. Charles
Pojanasomboon, Pichat, Rolla (Member St. Louis Medical Society)
Politi, Gregory, Kansas City
Politte, Lenard L., Columbia
Polk, George M., Sun City, Ariz. (Member Jackson County Medical Society)
Pollock, Leo H., Kansas City
Pontillas, Job B., Perryville
Poonawala, Huseni E., Kansas City
Poor, Carl W., Neosho
Pope, Charles H., Jr., Kansas City
Popp, Carl G., Sikeston
Porporis, Arthur A., St. Louis
Porter, Louis, Kansas City
Portugal, Antonio Q., St. Louis
Portuondo, Bonaventura C., St. Louis
Post, John P., Washington
Post, John R., Washington (Member St. Louis Medical Society)
Post, Lawrence T., Jr., St. Louis
Post, Stephen L., St. Louis
Post, Winfred L., Joplin
Potashnick, Robert, St. Louis
Potchen, E. James, Baltimore, Md. (Member St. Louis Medical Society)
Potter, Caryl A., Jr., St. Joseph
Potter, Lee G., Kansas City
Potter, Reese H., St. Louis
Potts, Donald A., Independence
Powell, Alan E., Independence
Powell, Charles B., Florissant
Powell, Earl A., St. Louis
Powell, Edwin M., Springfield
Powell, Nelson E., Kansas City
Powell, Robert G., Joplin
Powers, John M., Independence
Powers, Pierce W., St. Louis
Powers, William E., St. Louis
Prater, Bill G., Springfield
Pratt, Lindsay L., St. Louis
Prendergast, Thomas John, Jr., Columbia
Prensky, Arthur L., St. Louis
Presant, Cary A., St. Louis
Presnell, Cleitus A., St. Louis
Price, Kenneth C., St. Louis
Price, Robert L., Chesterfield
Prieto-Basa, Nenita, St. Louis
Printz, Joseph H., Kansas City
Printz, Otto J., Kansas City
Probst, Raymond E., St. Louis
Probstein, Jacob G., St. Louis
Proctor, Donald C., Sedalia
Prokop, Joseph R., St. Joseph
Prophete, B., St. Louis
Proskey, Vincent J., St. Louis
Pruett, Burchard S., St. Louis
Pruett, Don S., St. Louis
Pruett, Hubert S., St. Louis
Pruett, Paul L., Springfield
Prusaczyk, Joseph, Florissant
Pryor, Ira Joe, Joplin
Pu, Pin H., Kennett
Pucci, Gregory L., Kansas City
Pugh, Daniel D., St. Louis
Pugh, Reginald P., Pittsburgh, Pa. (Member Boone County Medical Society)
Pugh, Richard G., Independence
Pulliam, Morris W., St. Louis
Punhong, Prasert, St. Louis
Purcell, Harry K., St. Louis
Purcell, Paul L., Smithville (Member Marion-Ralls-Shelby County Medical Society)
Pyne, Herbert S., St. Louis
Pyron, Katharine A., Gulfport, Miss. (Member Clay County Medical Society)

Q

Quer, Erich A., Kansas City
Quick, Richard T., St. Louis
Quinn, Paul S., Springfield
Quistgard, Paul C., Hollister

R

Rabin, Erwin R., Topeka, Kan. (Member St. Louis County Medical Society)

Racadio, Severo M., Kirkwood
Racela, Antonio S., Jr., Kansas City
Rachlin, Maxwell, St. Louis
Rader, Ada B., Kansas City
Rader, Edward S., St. Louis
Rader, George B., St. Louis
Radke, John D., St. Louis
Ragland, Jerry, Warrensburg
Ragland, John E., Ballwin
Rahman, Mohammad H., St. Charles
Rahman, Moududur, St. Louis
Raich, Robert A., Kansas City
Rainey, Robert, St. Louis
Rainwater, Elmer H., Springfield
Rall, Kenneth L., Columbia
Ramey, Ehret O., Kansas City
Ramirez, Ricardo M., Poplar Bluff
Ramirez, Samuel G., St. Louis
Ramos, Americo G., Kansas City
Ramsey, Robert H., Florissant
Randolph, Bernard C., St. Louis
Rankin, Diane, St. Louis
Rannie, Paul R., Independence
Rao, A. R., Fredericktown
Rao, Carlo, St. Louis
Rao, S. N., St. Louis
Rao, V. Padmanabha, Springfield
Raper, Charles A., Poplar Bluff
Raphel, Jose, St. Joseph
Rapp, Earl L., Hannibal
Rapp, Harold B., Cape Girardeau
Rappold, H. O., St. Ann
Ratcheson, Robert A., St. Louis
Ratnam, Dasari V., Kansas City
Rauch, James E., Kansas City
Rawlins, Fred E., Cape Girardeau
Raybuck, Harry E., St. Louis
Raynor, Richard, Marshall
Raza, Syed A., St. Louis
Razek, A., St. Louis
Razzaq, A., Granite City, Ill. (Member St. Louis Medical Society)
Recano, Ricardo Q., St. Louis
Rector, Joe L., Jr., Kansas City
Reddin, Jack L., Independence
Reddin, Patrick C., Mexico
Reddy, Abbiah N., Poplar Bluff
Reddy, Kamalesh K., Kansas City
Reddy, Sarvotham K., Poplar Bluff
Redington, James C., Jr., Clayton
Redmond, William, St. Joseph
Reed, G. H., Appleton City
Reed, William A., Kansas City
Reeder, Charles C., Smithville
Reese, A. Victor, St. Louis
Reese, Lester T., St. Louis
Rhem, Ralph, Dexter
Reich, Harry A., St. Louis
Reichert, M. Cecelia, St. Louis
Reiches, Aaron J., St. Louis
Reid, James A., Marshall
Reider, Richard A., Warson Woods
Reimer, Donald R., Topeka, Kan. (Member Cape Girardeau County Medical Society)
Reineck, John A., St. Louis
Reinhard, Edward H., St. Louis
Reinhardt, George R., Kansas City
Reisa, Ronald C., St. Charles
Reisler, David M., St. Louis
Reiss, Jeanne E. L., Kansas City
Reister, Dorothy D., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Reister, Philip D., Kansas City
Reitman, Stanley, St. Louis
Rejent, Anthony, St. Louis
Rendleman, David D., Clayton
Rendleman, George F., St. Louis
Rendleman, George, Jr., St. Louis
Rengachary, Dhanalakshmi, Kansas City
Rennard, Marvin, St. Louis
Repaso, Florante A., Sullivan (Member St. Louis County Medical Society)
Repp, Theodore J., St. Louis
Reuter, Louis A., St. Louis
Revare, Paul, Kansas City
Reyes, Jose T., St. Louis
Reyes, Luis A., St. Louis
Reyes, Rosendo A., St. Louis
Reynolds, Clarence C., Kansas City
Reynolds, Fred, St. Louis
Reynolds, James A., Warson Woods
Reynolds, M. Wayne, Warrensburg
Rhee, Dong S., St. Louis
Rhee, Seoung Eun, St. Louis
Rhoades, Arthur B., Lenexa, Kan. (Member Jackson County Medical Society)
Rhodes, Andrew J,. Kansas City
Rhodes, Philip G., Kansas City
Ricci, Walter F., Kansas City
Rice, Carl E., Crystal City
Rice, Ronald, St. Charles
Richany, Shafik F., Kansas City

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* Doctor of Osteopathy.

Richards, Frank O., St. Louis
Richardson, George A., Union
Richardson, Marion W., Kansas City
Richardson, Thomas F., St. Louis
Richardson, William R., Union
Richert, Robert C., Kansas City
Richman, Elmer, Chesterfield
Richmond, Michael R., Florissant
Riddell, Richard V., St. Joseph
Ridenhour, C. E. Gene, Columbia
Ridgeway, William G., St. Louis
Ridings, Harold D., Cape Girardeau
Riekhof, Paul L., Kansas City, Kan. (Member Jackson County Medical Society)
Ries, Douglas A., St. Louis
Riffel, Gordon W., Bourbon
Riggio, Salvatore N., St. Louis
Rigney, Levi M., Springfield
Rikli, Arthur E., Tokyo, Japan (Member Boone County Medical Society)
Riley, Charles T., Richmond
Riley, John J., St. Louis
Riley, Joseph P., Jr., Parthenon, Ark. (Member Jackson County Medical Society)
Riller, Lowell E., Kansas City
Rinck, Edward C., Nevada
Rinck, William E., Kansas City
Ring, Edward M., St. Louis
Rink, Richard A., Columbia
Rinker, Carl T., Jr., Springfield
Riordan, Robert H., Kansas City (Member Clay County Medical Society)
Rippey, John H., Kansas City
Rising, Dean R., Springfield
Ritchie, Frances R., St. Louis
Ritter, C. John, Cape Girardeau
Ritter, Carl F., Cape Girardeau
Ritter, Hubert A., St. Louis
Ritter, Paul J., St. Louis
Ritter, Raymond A., Cape Girardeau
Ritter, Raymond A., Jr., Cape Girardeau
Ritterbusch, James K., Fulton
Rizzo, Adolfo E., St. Louis
Rizzo, Marco, St. Louis
Roach, Edward A., St. Charles
Roark, Michael, St. Louis
Robb, Harold Phillip, Jefferson City
Robben, G. Garry, St. Louis
Robbins, Judy C., Springfield
Roberts, Grosvenor G., Lee's Summit
Roberts, Harold K., Clayton
Roberts, Harold M., Kansas City
Roberts, Howard H., Joplin
Roberts, John P., Kirkwood
Roberts, John R., St. Louis
Roberts, Paul A., Sweet Springs
Roberts, Perry, Cape Girardeau
Roberts, Phyllis Grant, St. Joseph
Robertson, Frank G., St. Louis
Robertson, William D., Poplar Bluff
Robertson, William D., Kansas City
Robichaux, Eugene B., Excelsior Springs
Robinett, Wade V., Kansas City
Robins, Eli, St. Louis
Robinson, Arthur W., Kansas City
Robinson, Edith C., St. Louis
Robinson, E. Kip, Kansas City
Robinson, Gary Lewis, Springfield
Robinson, George G., Humansville
Robinson, Robert R., Jr., Salt Lake City, Utah (Member Boone County Medical Society)
Robinson, Van M., N. Kansas City (Member Clay County Medical Society)
Robinson, William J., Kansas City
Roblee, Melvin A., St. Louis
Roche, Maurice B., St. Louis
Roddy, Hugh John, St. Louis
Roden, Vernon J., St. Louis
Rodes, Ned D., Mexico
Rodgers, Elrie P., Columbia
Rodgers, George H., Overland Park, Kan. (Member Jackson County Medical Society)
Rodgers, Samuel U., Kansas City
Rodriguez, Gregorio L., Charleston
Rodriguez, Rolando A., Kansas City
Rodriguez, Ubaldo R., St. Louis
Roehrs, Marvin E., Marshall
Rofail, Amin A., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Rogers, Hunter Bryan, St. Louis
Rogers, John A., Clayton
Rogers, John T., St. Joseph
Rogers, Robert L., Kansas City
Rogers, Wallace, Jr., Columbia
Rohlfing, Edwin H., St. Louis
Roller, Merrill J., Hannibal
*Romito, Anthony, Kansas City
Roos, Albert, St. Louis

Roper, Charles L., St. Louis
Roper, Stanley D., Ozark
Rose, Charles W., Kansas City
Rose, Dalton K., St. Louis
Rose, John F., Chillicothe
Rosecan, Marvin, St. Louis
*Rosell, Louis V., St. Louis
Rosenbaum, Harry D., St. Louis
Rosenbaum, Herbert E., St. Louis
Rosenfeld, Henry, St. Louis
Rosenholtz, Mitchell J., Columbia
Rosenstein, Daniel Lesem, Columbia
Rosenthal, Irwin I., St. Joseph
Rosenthal, Randall, Clayton
Ross, Gilbert, Jr., Columbia
Rost, William B., St. Joseph
Roter, Alexander M., St. Charles
Roth, Alfred D., Kansas City
Roth, John J., Creve Coeur
Rother, Paul H., St. Charles
Rothman, David, St. Louis
Rothweiler, Robert J., St. Louis
Roufa, Joseph F., St. Louis
Roulhac, George E., St. Louis
Rouse, Ernest T., St. Louis
Roush, George, Jr., St. Louis
Roxas, Generoso P., St. Charles
Roy, Joseph A., Jennings
Royce, James J., Sarcoxie
Royce, Robert K., St. Louis
Royse, Roy P., Sullivan
Royston, Grandison D., Little Rock, Ark. (Member St. Louis Medical Society)
Rozen, Jay I., Kansas City
Rubenstein, Melvin, St. Louis
Rubin, Harvey P., Kansas City
Rubin, Robert, St. Louis
Rubin, Sidney, Kansas City
Rubnitz, Leon H., Kansas City
Rudi, Herbert J., St. Louis
Rudman, Richard, St. Louis
Rufe, John R., Kansas City
Ruff, T. Eugene, Poplar Bluff
Ruhling, Rudy, St. Louis
Runez, Manuel W., Cabool
Rusan, Thomas E., St. Louis
Russell, Barbara E., Rolla
Russell, Earl D., Springfield
Russell, Garth, Columbia
Russell, Herman E., St. Louis
Russell, James L., Kansas City
Russell, Joseph P., Jefferson City
Russell, Robert K., Raytown
Rutledge, John F., Festus
Ryan, David L., Trenton
Ryan, John B., Washington
Ryan, John H., St. Joseph
Ryan, John J., St. Louis
Ryan, Robert E., St. Louis
Ryan, Thomas J., Jefferson City

S

St. John, Thomas C., St. Louis
Sabates, Felix N., Kansas City
Sachar, Leo A., St. Louis
Safdar, Shabbir, Granite City, Ill. (Member St. Louis Medical Society)
Saferstein, Lester, Kansas City
Saghir, Marcel, St. Louis
Saha, Nitai C., Ballwin
Saha, Sudha R., Ballwin
Sala, Jose M., Springfield
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Salanga, P. B., St. Louis
Sale, Llewellyn, Jr., St. Louis
Salmon, Mickey L., St. Louis
Sammon, T. James, Springfield
Sammons, Harry C., St. Louis
Samuelson, Edward A., Kansas City
Sanchez, Abelardo B., St. Louis
Sanchez, Salvador Valera, St. Joseph
Sanders, Donald C., Kansas City
Sanders, George E., Excelsior Springs
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Sanders, Robert D., St. Louis
Sanders, Theodore E., St. Louis
Sanders, William F., Kausas City
Sandow, Theodore, Jr., Kansas City
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Santoro, Carlos G., Kansas City
Santos, Romeo I., Kennett
Santschi, Don R., Kansas City
Sargent, Alden P., Sikeston
Sargent, John P., Sikeston
Sasser, William F., St. Louis
Sato, George, St. Louis
Sauer, Donald C., St. Louis
Sauer, Gordon C., Kansas City

Sauer, Paul E., Springfield
Sauer, W. Nicholas, St. Louis
Sauvage, Jacques, St. Louis
Savci, Hasan D., St. Louis
Sawyer, Floyd E., Kansas City
Sawyer, James, St. Louis
Scales, Margaret B., Kansas City
Scanlon, Robert C., Springfield
Schaan, Robert C., St. Louis
Schaef, Mary L., St. Louis
Schaefer, George J., St. Louis
Schaefer, Glennon S., Jr., St. Louis
Schaeffer, Edward M., Springfield
Schaerer, Jacques P., St. Louis
Schaerrer, William C., Kansas City
Schaper, Ernest H., St. Louis
Schechter, Samuel E., St. Louis
Scheele, Paul M., St. Louis
Scheer, George E., St. Louis
Scheff, Harold, St. Louis
Scheibe, Robert G., St. Louis
Schengber, John S., St. Louis
Schertz, Truman B., N. Kansas City
Scheuber, Charles, Columbia
Schewe, Elmer J., Jr., Columbia
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Schmidt, C. Robert, Kansas City
Schmidt, Charles A., Gerald
Schmidt, Dennis A., St. Louis
Schmidt, Edwin H., St. Louis
Schmidt, Edmund M., St. Louis
Schmidt, Herbert J., Joplin
Schmidt, J. H., Jefferson City
Schmiemeier, Roy H., St. Louis
Schneider, Sam, St. Louis
Schneider, Thomas A., St. Charles
Schober, Charles C., St. Louis
Schoeberl, Cletus B., Joplin
Schoeck, Albert F., St. Louis
Schoedinger, George R., III, St. Louis
Schoenberg, Harry W., St. Louis
Schoentag, John S., St. Louis
Schokker, Johannes, Jefferson City
Schonfeld, Gustav, St. Louis
Schoolman, Arnold, Kansas City
Schopp, Alvin C., St. Louis
Schottman, Gerhard W., Jr., Kansas City
Schranck, Charles R., St. Louis
Schreiber, Norman J., Springfield
Schroeder, Henry A., W. Brattleboro, Vt. (Member St. Louis Medical Society)
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Schuessler, Wolfgang P., St. Louis
Schuetz, Alfred, St. Charles
Schulte, Gregory A., Joplin
Schultz, E. Robert, St. Louis
Schultz, Irwin, St. Louis
Schultz, Robert V., Liberty
Schultz, Samuel, St. Louis
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Schutz, Richard B., Kansas City
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Schwartz, Frederick O., St. Louis
Schwartz, Henry G., St. Louis
Schwartz, Melvin M., St. Louis
Schwartzman, Bernard, St. Louis
Schwarz, Luis, Clayton
Schweiss, John F., St. Louis
Sciortino, Gaspare, St. Louis
Sciortino, John S., St. Louis
Scopelite, Joseph A., St. Louis
Scorse, Sidney W., Joplin
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Scott, Elwin P., St. Louis
Scott, Horace W., St. Louis
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Seabaugh, Ottis D., Webster Groves
Seabaugh, William O. L., Cape Girardeau
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See, William B., Columbia
Seeley, James J., St. Louis
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Seib, George A., St. Louis
Seiden, Gerald D., Kansas City
Seitz, Elson F., Kansas City
Sells, Kenneth J., Kansas City
Sengupta, Dipak K., St. Louis
Senhauser, Donald A., Columbia

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* Doctor of Osteopathy.

Senne, Herbert C., St. Joseph
Sennott, John S., Jefferson City
Senor, Samuel E., St. Joseph
Senturia, Ben H., St. Louis
Senturia, Hyman R., St. Louis
Serth, George O., St. Louis
Sertl, James F., Ballwin
Sertl, John D., St. Louis
Sessions, Donald G., St. Louis
Sethabutra, Chaisiri, St. Louis
Sevastianos, Aristides E., St. Louis
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Sexton, Elmer E., St. Louis
Shackelford, Horace H., St. Louis
Shackter, Bruce I., Springfield
Shah, Anwar, St. Louis
Shah, F. Naheed, St. Louis
Shah, Jitendra, St. Louis
Shahan, Philip T., St. Louis
Shaikun, Gerald L., Chesterfield
Shalet, Malcolm F., Kansas City
Shalley, Jack E., Kansas City
Shanahan, Mary Patricia, Joplin
Shanahan, Phil J., St. Louis
Shane, Ramon A., Springfield
Shaner, John F., St. Louis
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Shank, Rohert E., St. Louis
Shanks, William D., St. Louis
Shapiro, Herbert N., St. Louis
Shapiro, Lazare M., Kansas City
Shapleigh, John B., St. Louis
Sharp, Austin R., Ballwin
Shatz, Burton A., St. Louis
Shaw, Edward J., St. Louis
Shaw, William J., Jr., Fayette
Shea, James G., Washington
Sheahon, John A., Kansas City
Shechter, Nathan, Kansas City
Sheffield, William, St. Louis
Shelden, Russell D., Kansas City
Shell, William C., Sikeston
Shelton, Earl W., St. Louis
Shelton, Edward O., Eldon
Shelton, R. Wayne, Springfield
Shen, Jerome T. Y., St. Louis
Sheppard, Julius K., St. Joseph
Sheridan, Edmund R., St. Louis
Sherman, Warren G., St. Louis
Sherwin, Charles S., St. Louis
Shevlin, Charles F., St. Joseph
Shieher, William, St. Louis
Shields, J. B., St. Louis
Shifrin, Alexander, Kansas City
Shipp, Robert H., Chesterfield
Shireman, Kenneth L., Kansas City
Shirey, Arnold G., Hayti
Shmock, Carlton L., Kansas City
Shobe, Frank O., St. Louis
Shockley, Clarence J., Greenwood
Shoss, Milton, Cape Girardeau
Shriver, Ronald G., Poplar Bluff
Shuey, Herbert H., Kansas City
Shull, George D., Jefferson City
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Shumate, L. St. Clair, Reeds Spring
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Sicat, Luzviminda F., Jefferson City
Siceluff, Joseph G., Springfield
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Siemers, George E., St. Louis
Siesener, Herbert H., St. Louis
Sievers, Edward F., Hollywood Beach, Fla.
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Sigmund, Charles A., St. Ann
Signorelli, Andrew J., St. Louis
Silliman, York E., Joplin
Silshy, Don J., Springfield
Silsby, Harry D., Springfield
Silver, Bernd, St. Louis
Silverberg, Charles, St. Louis
Silvermintz, Saul D., Ladue
Silvers, Robert G., Olivette (Member Boone County Medical Society)
Simmons, Donald D., Kansas City
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Simmons, Jess S., Jr., Joplin
Simmons, John L., St. Louis
Simms, Otho M., St. Charles
Simon, David L., St. Louis
Simon, Jerome I., St. Louis
Simon, Nathan M., St. Louis
Simon, Sanford, Kansas City
Simowitz, Fredric M., St. Louis
Simpson, Albert P., Springfield
Simpson, Emerson L., Springfield
Simril, Wayne A., St. Louis
Sims, William A., Jr., St. Louis
Sinclair, Richard H., Kansas City
Sincox, Charles H., Washington
Singhal, Gokul S., St. Louis
Singhal, Renu, St. Louis
Singleton, Chas. M., II, Kansas City
Singleton, John M., III, Kansas City
Singleton, Marvin A., Joplin
Sirintrapun, Seyvee, Festus
Siripipat, Pallop, Mexico
Sirridge, Marjorie S., Kansas City
Sirridge, William T., Kansas City
Sisk, James C., St. Louis
Sislen, Donald, St. Louis
Sisler, Maynard Lee, Kennett
Sisson, Richard G., St. Louis
Siu, Kenneth K. C., Jefferson City
Skeffington, Mary Jane, St. Louis
Skilling, David M., Jr., St. Louis
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Skimming, W. Lee, Olivette
Skinner, John S., St. Louis
Skinner, John T., Kansas City
Sklenar, Donald E., St. Joseph
Slankard, J. Edward, Kansas City
Slaughter, Carl R., Kansas City
Slentz, Edwin L., Kansas City
Slentz, William A., Kansas City
Sletten, Ivan W., St. Louis
Slickman, Robert A., Kansas City
Sly, William S., St. Louis
Smiley, William, St. Louis
Smit, Herbert M., St. Louis
Smith, Arthur B., Kansas City
Smith, Benjamin F., Jr., St. Louis
Smith, C. Franklin, Willow Springs
Smith, C. Souter, Springfield
*Smith, Charles H., Kansas City (Member Clay County Medical Society)
Smith, Dermott, St. Louis
Smith, Elbert E., III, Kansas City
Smith, Emily, St. Louis
Smith, Garland F., St. Louis
Smith, Herhert P., St. Louis
Smith, Hubert E., Kansas City
Smith, Hugh R., St. Louis
Smith, Ira T., Kansas City
Smith, J. Earl, St. Louis
Smith, James B., St. Louis
Smith, James M., Kansas City
Smith, James O., Clinton
Smith, Jason N., Jr., Columbia
Smith, Joe R., Columbia
Smith, John R., St. Louis
Smith, Katherine W., Kansas City
Smith, Kathleen, St. Louis
Smith, Kenneth R., Jr., St. Louis
Smith, Morton E., St. Louis
Smith, Norris W., St. Louis
Smith, Othello D., Kansas City
Smith, Robert W., Brookfield
Smith, Roland T., Joplin
Smith, Rollin H., West Plains
Smith, Sidney E., St. Louis
Smith, Ted P., Rolla
Smith, Wallace B., Independence
Smith, William J., Windsor
Smith, W. Russell, Carthage
Smolik, Edmund A., St. Louis
Smoller, Martin B., St. Charles
Smull, Ned W., Kansas City
Snead, William H., Jr., Springfield
Sneid, Philip, Kansas City
Snider, Wilbur R., Independence
Soliman, Fauzi, St. Louis
Solley, Robert F., Old Saybrook, Conn.
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Somers, John E., Columbia
Sommer, Conrad S., St. Louis
Sommer, Ross B., St. Louis
Somoza, Jose, Kansas City
Soorya, Narendir T., St. Louis
Soper, Steven J., Independence
Soper, William D., Excelsior Springs
Sopuch, John A., St. Louis
Sosebee, Lee A., Columbia
Soto, Alberto A., St. Louis
Soucy, John C., St. Charles
Soule, Samuel D., Clayton
Spafford, Allen L., Kansas City
Spalding, David L., Springfield
Spalding, Donald G., St. Louis
Spalding, Wilber B., Plattsburg
Spalding, Wilber B., Jr., Kansas City
Sparkman, Thomas C., Cape Girardeau
Spears, Charles A., Branson
Spears, Joe L., Cabool
Spector, Gene W., St. Louis
Spector, Gershon J., St. Louis
Spence, Paul A., Cape Girardeau
Spencer, Donald M., Kansas City
Speno, Angelo A., St. Louis
Spies, Barbara J., Kansas City
Spinzig, Edgar W., Kirkwood
Spitz, Milton A., Chicago, Ill.
(Member St. Louis County Medical Society)
Spitz, Richard H., St. Louis
Spoeneman, Marlin C., St. Louis
Spoenemann, Walter H., St. Louis
Sponenberg, Don D., Springfield
Sportsman, Weldon L., Kansas City
Spratt, John S., Jr., Columbia
Sprinz, Helmuth, Kansas City
Spurgeon, Milo J., Columbia
Spurney, Joe E., Kansas City
Spurny, Otto M., Kansas City
Squitieri, A. J., St. Louis
Stacey, Wallace R., Independence
Stacy, Winton T., St. Joseph
Stafford, Walter R., St. Louis
Staggs, William A., Kansas City
Staley, Harry R., Kansas City
Stallard, Donald J., St. Joseph
Stanfield, Ned M., Jr., St. Louis
Stanley, John H., Kansas City
Stanley, Robert J., St. Louis
Staple, Tom W., St. Louis
Starkloff, Gene B., St. Louis
Starkloff, Max, St. Louis
Statland, Harry, Kansas City
Statland, Morris, Kansas City
Staton, R. Hamilton, Carrollton
Stauffacher, C. Gordon, Sedalia
Stauffer, Harry B., Jefferson City
Steele, Jack T., St. Louis
Steele, James C., Jr., Hannibal
Steffen, Lawrence F., Kansas City
Stegman, Elmer G., Raytown
Stein, Arthur H., Jr., St. Louis
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Stephen, C. Ronald, St. Louis
Stephens, Jack D., Kansas City
Stephens, LeRoy J., St. Louis
Stephens, William A., Chesterfield
Stephenson, Hugh E., Jr., Columbia
Stergen, Nick E., Florissant
Sterkel, Richard L., St. Louis
Sterling, John A., Kirkwood
Stevens, Edward M., St. Joseph
Stevens, Robert W., St. Louis
Stewart, Frances H., St. Louis
Stewart, Harry A., Kansas City
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Stewart, Robert H., Sedalia
Stewart, R. Wendell, Springfield
Stewart, Wellington B., Columbia
Stewart, Wendell K., Cape Girardeau
Stewart, William J., Columbia
Stickle, Arthur W., St. Louis
Stickler, Ralph O., Kirksville
Stindel, Charles E., St. Louis
Stockton, Raymond W., Kansas City
Stockwell, A. Lloyd, Kansas City
Stockwood, Robert C., Sedalia
Stohr, Paul E., St. Louis
Stokes, James M., St. Louis
Stolar, Jacoh, St. Louis
Stoneman, William, III, St. Louis
Stotts, Charles S., Fredonia, Kan.
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Stoy, Robert P., Columbia
Strader, Richard P., St. Louis
Stradford, H. Todd, Columbia
Stratemeier, Edward H., Kansas City
Stratman, Clarence A., Kansas City
Straub, David L., Joplin
Strauchen, Gilbert W. N., Key Largo, Fla.
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Strauss, Arthur E., St. Louis
Strauss, Carl F., Kansas City
Streetor, Roderick D., St. Louis
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Strehlman, Benjamin G., Union
Stribling, Thomas L., Independence
Stricker, Emil A., St. James
Stricker, Harold C., Jefferson City
Strobach, Robert L., Butler
Strominger, Donald B., St. Louis

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Struessel, Kenneth F., Columbia
Stryker, Garold V., Venice, Fla. (Member St. Louis Medical Society)
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Stuart, Byron M., Boonville
Stuart, Daniel D., Brunswick
Stuart, Wallace, St. Louis
Stubblefield, Wayne, Springfield
Stuber, Jack L., Kansas City
Stuber, Robert R., St. Joseph
Stuebner, Roland W., Marco Island, Fla. (Member St. Louis County Medical Society)
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Sturtevant, Harwood N., Springfield
Stutsman, Albert C., St. Louis
Suba, Antonio R., St. Louis
Suddarth, Sterling B., Kansas City
Sudholt, Alfred F., Jr., St. Ann
Sugar, Robert L., Kansas City
Sugarbaker, Everett D., Jefferson City
Sullivan, Clement J., St. Louis
Sullivan, Dan T., Springfield
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Sumathy, Vannarth, Kansas City
Sumer, Cengis M., St. Louis
Summers, John B., St. Louis
Summers, Joseph S., Jr., Jefferson City
Summers, Thomas F., St. Louis
Sundaram, Shankar, St. Louis
Sunderman, Raymond C., St. Louis
Sundstrom, Frank D., Springfield
Sunshine, Herbert, St. Louis
Susanka, William D., St. Louis
Suseela, Dasari, Kansas City
Susman, Irvin C., St. Louis
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Sword, Richard O., Kansas City
Sydow, Henry A., Fulton
Szabados, Ernest D., Independence
Szymanski, Stanley R., Macon (Member Grand River Medical Society)

T

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Tang, Theodoro C., St. Louis
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Tarvydas, Francis, Edina
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Tatkow, Robert W., St. Louis
Taussig, Barrett L., St. Louis
Taute, Herman, St. Louis
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Taylor, Eugene D., St. Louis
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Taylor, Helen L., St. Louis
Taylor, Herbert B., St. Louis
Taylor, Leo T., Neosho
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Taylor, Loren F., Kansas City
Taylor, Van W., Bonne Terre
Taylor, William E., Springfield
Tayob, Anver A., St. Louis
Teiber, Frederick W., St. Louis
Tejero, Jonas S., St. Charles
Tekwani, Hiralal, St. Louis
Temporal, Jose A., St. Louis
Tendai, Mark M., Springfield
Ternberg, Jessie L., St. Louis
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Terry, James F., Springfield
Terry, James W., Jr., Cape Girardeau
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Tharp, Judith, Platte City
Theel, Otto W., Jr., Kansas City
Theobald, Sterling, Camdenton
Thiel, J. Allen, St. Louis
Thiele, Belmont R., St. Louis
Thiele, George H., Kansas City
Thiele, Otto K., St. Charles
Thierauf, Charles G., St. Louis
Thies, Jerome H., Osceola
Thind, Sevinder S., St. Louis
Thoma, George E., Jr., St. Louis
Thomas, Christopher Y., Jr., Kansas City
Thomas, Fred A., Kansas City
Thomas, Horace E., Columbia
Thomas, Lewis J., Jr., St. Louis
Thomas, Robert M., Columbia
Thomas, Thomas C., Liberty
Thomasson, David D., Springfield
Thompson, Charles L., Kansas City
Thompson, F. Gregg, III, St. Joseph
Thompson, Ian M., Columbia
Thompson, M. Bryant, St. Louis
Thomson, James Myron, Jr., Columbia
Thornton, Fred H., Sikeston
Throgmorton, Howard B., Sikeston
Throne, Bennie J., Kansas City
Throne, Elias M., Kansas City
Thurman, Hill C., Parkville
Thurmann, Manfred, St. Louis
Thym, Henry P., Ballwin
Tice, Wayne K., Independence
Tichenor, Robert W., St. Louis
Tietjen, Frederick O., Jefferson City
Tiffany, Delbert E., Poplar Bluff
Till, Bennie N., Poplar Bluff
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Tillman, Mary A. T., St. Louis
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Tjoflat, Oliver E., St. Louis
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°Toon, Thomas J., St. Louis
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Tsang, John L. K., Springfield
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Tucker, Eugene F., St. Louis
Tucker, George L., St. Louis
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Turner, Glenn O., Springfield
Turner, James H., Poplar Bluff
Turner, James K., St. Louis
Turner, Kirby L., Poplar Bluff
Turner, Ronald M., Independence
Turner, Rush, St. Louis
Turner, William F., Poplar Bluff
Tutera, Dominic F., Kansas City
Tuthill, Herbert, Kansas City
Tuttle, Jay F., Farmington
Twedell, Donald L., St. Louis
Twin, Edward J., Kansas City
Twyman, Richard A., Kansas City
Tygett, Glenn J., Cape Girardeau
Tygett, Joseph N., Cape Girardeau

U

Uhlemeyer, Henry A., St. Louis
Ulett, George A., St. Louis
Ulett, Pearl C., St. Louis
Umali, Emil C., St. Louis
Underwood, Dick H., Kansas City
Underwood, Johnson, Jr., Kansas City
Underwood, Johnson, III, Kansas City (Member Clay County Medical Society)
Ungvari, Joseph C., St. Louis
Upsher, Albert E., Kansas City
Urban, Edgar D., Sikeston
Ureta, Emerito F., St. Louis
Utley, James H., St. Louis
Utterman, William F., Ste. Genevieve

V

Vacca, Joseph B., St. Louis
Vafi, Houshang, St. Charles
Vajaranant, Manit, Lexington
Valach, Frank J., St. Louis
Valdes, Orestes S., Chesterfield
Valins, Eugene, Kansas City
Valtierra, Cesar A., St. Louis
Van Biber, James T., Independence
Van Buskirk, Terrance E., Kansas City
Van Buskirk, William C., Kansas City
Van Dervoort, Robert L., Jr., Columbia
Vandiver, Virgil D., Chillicothe
Vandover, John T., St. Louis
Van Dyke, Elmer H., Sedalia
VanGoidsenhoven, Guy, St. Louis
Van Matre, R. M., Washington, D. C. (Member St. Louis Medical Society)
Van Norman, Robert T., St. Louis
Van Thullenar, Philip A., Kansas City
Van Vranken, Eugene E., Jefferson City
Vardeleon, Roger V., St. Louis
Vargas, Teodoro C., Manchester
Varma, D. K., Poplar Bluff
Vart, Gary R., St. Charles
Vatterott, Paul B., St. Ann
Vaughan, J. Russell, St. Louis
Vaughan, Robert W., St. Louis
Vaughn, James W., Kansas City
Velasco, Ernest, St. Louis
Veluz, Benito I., St. Louis
Vensel, Lee H., Springfield
Ventus, Manuel A., Chesterfield
Vera, Enrique, Kansas City
Verda, Dominic J., St. Louis
Verde, Julian N., St. Louis
Vergara, Gerardo S., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Vermeire, David A., Kansas City
Verzola, Eufemio, St. Louis
Vescovo, Paul C., Jr., Kansas City
Vest, James C., St. Louis
Viamontes, Jorge A., St. Louis
Vianzon, Elizabeth, St. Louis
Victor, Frank R., Kansas City
Vidals, Victor G., Kansas City
Vidheecharoen, S., Florissant
Viers, Wayne A., St. Louis
Vigor, William, St. Louis
Vijungco, Herminia D., Chesterfield
Vilar, Pio M., Jr., Chesterfield
Villadiego, Virgilio, St. Louis
Villahermosa, Juanito L., Savannah
Villamar, Elizabeth N., St. Louis
Villaneuva, Angela A., Prairie Village, Kan. (Member St. Louis Medical Society)
Villanueva, Cesar, Kansas City, Kan. (Member St. Charles-Lincoln County Medical Society)
Villarama, Antonio P., Ballwin
Villarama, Lilia F., Manchester
Vilmer, Charles, N. Kansas City
Viloria, Alberto B., St. Louis
Vincent, Jack C., Kansas City
Vinson, Harold A., Tulsa, Okla. (Member Jasper County Medical Society)
Vinyard, Jack L., Joplin (Member Grand River Medical Society)
Viraghaty, Julius G., Glencoe
Virant, John A., St. Louis
Virden, Herbert, Kansas City
Viril, Leonardo C., Kansas City
Vitale, Anthony J., St. Louis
Vitale, Nicholas S., St. Louis
Vitt, Alvin E., St. Louis

° Doctor of Osteopathy.

Vitt, Edwin F., St. Louis
Viviano, Joseph G., St. Louis
Vogel, Arthur P., Kansas City
Volk, George E., Kansas City
Vollmar, Clarence J., Webster Groves
Votaw, Robert E., St. Louis
Voth, Harold W., Kansas City
Vournas, Christopher G., St. Louis

W

Wacker, Leo L., St. Louis
Waddell, Kenneth E., Springfield
Waddell, Thomas H., Kansas City
Waddle, Theodore L., Dexter
Wade, Frederick E., Kansas City
Wade, James P., St. Louis
Wadlow, Ernest E., St. Joseph
Waggoner, Charles M., Columbia
Waggoner, Sharon E., St. Joseph
Wagner, John R., St. Louis
Wagner, Paul J., Kansas City
Wakefield, Franklin H., Sun City, Ariz. (Member Jackson County Medical Society)
Wakeman, Jasper N., Springfield
Wakeman, Jasper Newton, Jr., Springfield
Wakerlin, G. E., Columbia
Wald, Donald M., North Kansas City
Wald, Stanley M., St. Louis
Waldman, Richard A., Kansas City
Walker, Ambrose T., Thayer
Walker, Francis S., St. Louis
Walker, Harvey, Jr., St. Louis
Walker, J. Leslie, St. Louis
Walker, James C., Kansas City
Walker, John W., Kansas City
Walker, Orville C., Jr., Independence
Walker, Paul W., Joplin
Walker, Willard B., Clayton
Walker, William M., Springfield
Wall, Harry C., Kansas City
Wall, Joe A., Houston
Wall, Leonard A.. Kansas City
Wall, Lester E., St. Louis
Wallace, Darryl L., Wichita Falls, Tex. (Member Jackson County Medical Society)
Wallace, Edgar S., Mexico
Wallace, Hilen K., St. Joseph
Wallace, John K., II, Jefferson City
Wally, John W., Kansas City
Walsh, James W., St. Louis
Walter, Archie L., Sedalia
Walter, Kenneth E., St. Louis
Walter, William L., St. Louis
Walters, Harold E., St. Louis
Walters, Henry W., St. Louis
Walters, John H., Columbia
Walters, Laura, Columbia
Walters, William H., St. Louis
Walterscheid, John H., Hannibal
Walther, Roy A., Jr., Ballwin
Waltman, Stephen, St. Louis
Walton, Franklin E., St. Louis
Waltrip, Roy T., Jr., Sikeston
Waltz, Charles A., Kansas City
Waltz, James R., Kansas City
Wanamaker, John M., Rock Port
*Wang, George Y. M., Kansas City
Wantuck, Donald K., Springfield
Ward, Joe, Lexington
Ward, Robert L., St. Louis
Warren, James C., St. Louis
Warren, William H., Springfield
Warres, Herbert L., Springfield
Washburn, J. Loren, Versailles
Washington, Edward L., Columbia
Washington, Walter, St. Louis
Wasserman, Helman C., St. Louis
Waterfield, Jim R., Springfield
Waterman, Franklin M., Liberty
Waters, Hugh R., St. Louis
Wathanacharoen, Suchint, Kansas City
Watkins, George L., Jr., La Jolla, Calif. (Member Mineral Area County Medical Society)
Watson, Cecil L., Lincoln, Ill. (Member Saline County Medical Society)
Watson, Ethel, Independence
Watson, Trevor F., Columbia
Wattenberg, Carl A., St. Louis
Watts, Byron E., Jefferson City
Waxelman, Roger J., Manchester
Waxman, Herbert J., Kansas City
Waxman, Jane Z., Kansas City
Wayland, Thomas A., Camdenton
Wayne, Sherwyn J., Kirkwood
Webb, Harry E., Kansas City
Webb, Leslie R., Jr., Springfield
Webb, Marion A., Clayton
Webb, Paul B., St. Louis
Webb, Paul B., Jr., St. Louis
Webb, Paul K., St. Louis
Webber, Wm. B., St. Louis
Weber, J. R., St. Louis
Weber, Sol, St. Louis
Wee, George C., Ellisville
Weed, Randal W., St. Joseph
Weeks, George R., Cape Girardeau
Weeks, Paul M., St. Louis
Weidmaier, Edward J., Kansas City
Weiford, Edward C., Kansas City
Weiler, Thomas J., St. Louis
Weinand, Ernest E., St. Joseph
Weinhaus, Robert S., St. Louis
Weir, Don C., St. Louis
Weir, Robert K., Kansas City
Weir, Royal A., Ballwin
Weis, Matthew W., Villa Ridge
Weisman, Renate D., St. Ann
Weiss, James M. A., Columbia
Weiss, Stuart, St. Louis
Weldon, Clarence S., St. Louis
Well, Julius W., Palmyra
Wells, Donald E., Kansas City
Wells, James A., Kansas City
Wells, John H., Kansas City
Welner, Amos, St. Louis
Welsh, Laurence C., St. Louis
Wempe, G. Raymond, Maryville
Wenneker, Alvin S., St. Louis
Wenner, Herbert A., Kansas City
Wentzel, Louis R., St. Louis
Werner, Dean F., N. Kansas City
Werner, Franklin C., Kansas City
Werner, William A., St. Louis
Werth, Joseph, Jefferson City
Wessler, Stanford, St. Louis
West, Harold D., Kansas City
West, Joseph W., St. Louis
Westerfeld, Roy A., St. Charles
Westerman, Henry C., St. Louis
Westerman, Robert N., St. Louis
Westrup, Ellsworth A., Webster Groves
Wetzel, Gus S., Clinton
Weyerich, Leon F., St. Louis
Weyerich, Noel F., Chesterfield
Weygandt, Glenn R., St. Louis
Wheeler, Charles B., Kansas City
Wheeler, John H., Kansas City
Wheeler, Paul C., Columbia
Wheeler, Robert L., Harrisonville
Whitaker. Topsy H., East Prairie
White, Barry B., Poplar Bluff
White, Bruce I., St. Louis
White, Charles H., Kansas City
White, Eugene F., Rolla
White, James S., Kansas City
White, Joseph, Columbia
White, Newton B., St. Louis
White, R. Ned., Springfield
White, Stoughton F., Kansas City
White, William E., Kansas City
White, William H., Jr., St. Louis
Whiteman, John R., Kansas City
Whitener, Miles C., St. Louis
Whitener, Paul R., St. Ann
Whitlock, C. Courtney, Springfield
Whitman, Doyle C., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Whitmore, J. Stewart, Kansas City
Whitsell, Ora E., St. Joseph
Whittaker, Charles K., Kansas City
Whitten, John S., Independence
Whitten, Marion F., Carthage
Whittico, James M., St. Louis
Wicks, Edwin O., Kansas City
Wiedershine, Leonard J., St. Louis
Wiegand, Herbert C., St. Louis
Wieman, Harry K., Joplin
Wien, Irving A., Kansas City
Wiggins, Roland L., Columbia
Wilber, Robert D., Kansas City
Wilbers, Raymond H., Mexico
Wilbois, Ronald P., St. Louis
Wilcox, Ruth E., Joplin
Wilcoxen, William B., Bowling Green
Wiles, Jack N., West Plains
Wilhelm, Warren F., Kansas City
Wilkinson, Charles B., Kansas City
Wilkinson, Everett A., Kansas City
Willcoxon, Robert L., Joplin
Williams, Carol F., St. Louis
Williams, Frank R., Kansas City
Williams, George P., Kansas City
Williams, Jerome, St. Louis
Williams, John M., Liberty
Williams, John W., Oak Grove
Williams, John W., Springfield
Williams, John W., Jr., Springfield
Williams, Joseph C., Jr., Kansas City
Williams, Ray D., St. Louis
Williams, Robert D., Kansas City
Williams, Robert S., Mexico
Williams, Roland D., Kansas City
Williams, Starks J., Kansas City
Williams, Thomas A., Leawood, Kan. (Member Clay County Medical Society)
Williamson, George L., N. Kansas City
Williamson, Walter E., St. Louis
Willis, H. Robert, St. Louis
Willman, Charles R., St. Joseph
Willman, Vallee L., St. Louis
Willoughby, James W., Kansas City
Willoughby, Jean B., Kansas City
Willumsen, Henry C., St. Joseph
*Wilson, A. W., St. Louis
Wilson, Alice H., Neosho (Member Jasper County Medical Society)
Wilson, Charles F., Cape Girardeau
Wilson, Clifford C., Kansas City
Wilson, Fred K., Winston
Wilson, George P., Columbia
Wilson, Hugh M., St. Louis
Wilson, John E., Columbia
Wilson, Keith S., Clayton
Wilson, Loys C., Kennett
Wilson, Roy E., Springfield
Wilson, Susan L., St. Louis
Wilson, Vernon E., Columbia
Wilucki, Melvin R., St. Louis
Wimmer, Warren J., St. Louis
Windmiller, Myrl E., Columbia
Windsor, Charles E., St. Louis
Windsor, David G., Rosendale (Member Buchanan County Medical Society)
Winegar, Alvon C., Jefferson City
Winer, Herbert J., Kansas City
Winer, Nathaniel, Kansas City
Winkelman, Esther B., Kansas City
Winn, George W., Boonville
Winsky, Arlen D., Springfield
Winston, Bernard H., Kansas City
Winter, John H., St. Louis
Winter, Tyrus D., St. Louis
Winterer, Roland A., St. Louis
Winters, Kathleen, St. Louis
Wipfler, Earl J., Jr., St. Charles
Wirth, Fremont P., St. Louis
Wirthlin, Edward H., St. Louis
Wise, George W., Kansas City
Wise, Gordon F., Springfield
Wise, Leslie, St. Louis
Wise, Morris F., Kansas City
Wissmath, Frank S., Clayton
Wissner, Seth, St. Louis
Withers, Orval R., Kansas City
Witbrow, John B., N. Kansas City (Member Clay County Medical Society)
Witt, Clyde M., St. Louis
Witt, Frederick W., St. Louis
Wittgen, Edward M., St. Louis
Wittler, Harry A., St. Louis
Wittmer, Samuel C., Springfield
Wochner, R. Dean, St. Louis
Woehl, Joseph J., Kansas City
Wolf, David I., St. Louis
Wolf, Jack W., Kansas City
Wolfe, Edward, St. Louis
Wolff, Dolores P., St. Louis
Wolff, Gerald, St. Louis
Wolff, Harold D., St. Louis
Wolff, Paul G., Cape Girardeau
Wolff, Ray J., St. Ann
Wolfgram, Edwin D., St. Louis
Wolfram, Philip H., Smithville (Member Platte County Medical Society)
Womack, Granville J., Maryland Heights
Wommack, Fred L., Crane
Wong, George, Jr., Springfield
Wood, Bennett R., St. Louis
Wood, George F., Fulton
Wood, George H., Carthage
Wood, James A., Clayton
Wood, Tom, Poplar Bluff
Wood, William W., West Plains
Woodman, Grey M., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Woodruff, Calvin W., Columbia
Woodruff, Robert A., Jr., St. Louis
Woodruff, Sharon, Washington (Member St. Louis County Medical Society)
Woods, Harold V., Blue Springs
Woods, John F., Advance
Woods, Ralph E., Clayton
Woods, S. Dwight, Kansas City
Woods, Walton C., Kansas City
Woodward, William W., Kansas City
Wool, Gerald, St. Louis
Wooldridge, Bart F., Joplin
Wooldridge, Wilfred E., Springfield
Woolsey, Joyce E., St. Louis
Woolsey, Robert M., St. Louis
Word, Parker H., St. Louis
Workman, Charles E., N. Kansas City (Member Clay County Medical Society)
Workman, George M., Hermann
Worley, Charles A., Sweet Springs
Wortmann, Robert F., Kansas City
Wotawa, William J., St. Louis

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* Doctor of Osteopathy.

Wray, Rolla B., Nevada
Wray, R. C., Jr., St. Louis
Wright, Earl J., Kansas City
Wright, Robert P., Kansas City
Wu, Shuh-Min, Kansas City
Wu, William Q., Kansas City
Wulff, George J. L., Jr., St. Louis
Wurr, Dieter, Arnold
Wurster, Jerry B., Kansas City
Wurster, W. Joel, Kansas City
Wyatt, Lois C., Kirkwood
Wyrsch, Leo M., Jr., Springfield

Y

Yaeger, Gerald A., St. Charles
Yalcin, Enver, St. Louis
Yancey, Daniel L., Springfield
Yannakakis, John E., Florissant
Yanow, Mitchell, St. Louis
Yap, Mardonio J. R., St. Louis
Yasin, Fazle Mobin, St. Louis
Yates, Darrel W., St. Louis
Yazdi, A. M., St. Louis
Ylagan, Amando, Jr., St. Louis
Yoon, Jin Soo, Chillicothe
Yore, Richard W., St. Louis
Yoskit, Harry, Festus
Youll, Donald V., Kansas City
Youmans, Ronald A., Kansas City
Young, Calvin C., Jr., Joplin
Young, James E., Kansas City
Young, Jesse W., Kansas City, Kansas (Member Jackson County Medical Society)
Young, Paul R., Columbia
Young, Robert B., Rolla
Young, Robert H., Moberly
Youngblood, James P., Kansas City
Younge, Walter A., Lovejoy, Ill. (Member St. Louis Medical Society)
Younger, Anita, St. Louis
Younger, Ernest, St. Louis

Z

Zacharias, David L., Kansas City
Zahn, Robert L., Springfield
Zahony, Ivan, Kansas City
Zahorsky, Carroll L., Kansas City
Zahorsky, Theodore S., St. Louis
Zeffren, Joel L., St. Louis
Zeigler, Joseph M., Creve Coeur
Zekert, Horst, St. Louis
Zellermayer, Jacob, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Ziegelmeyer, John S., St. Louis
Ziegler, Anthony, Jr., Conroe, Tex. (Member Audrain County Medical Society)
Zimmerman, Herbert B., St. Louis
Zimmerman, Joseph A., Kennett
Zingale, Frank G., St. Louis
Zink, Oscar C., St. Louis
Zinn, Marsha V. E., Kansas City
Zivnuska, Fred R., St. Louis
Zografakis, George H., St. Louis
Zoller, David D., Kansas City
Zuckner, Jack, St. Louis
Zukowski, Edward T., Chesterfield
Zwart, Claude H., St. Louis
Zwerenz, Bruno H., Kansas City
Zwirn, Benjamin H., Florissant

Component Society Meeting Dates

Audrain County Medical Society—third Tuesday of each month.
Andrew County Medical Society—meets only on call.
Barton-Dade County Medical Society—third Wednesday of each month.
Benton County Medical Society—meets only on call.
Boone County Medical Society—first Tuesday of each month at 7 p.m.
Buchanan County Medical Society—first Wednesday of each month.
Butler-Wayne-Ripley County Medical Society—first Wednesday of each month.
Callaway County Medical Society—third Thursday of each month.
Cape Girardeau County Medical Society—first Monday of each month.
Chariton-Macon-Monroe-Randolph County Medical Society—second Thursday of each month, September through May.
Clay County Medical Society—fourth Tuesday of each month.
Clinton County Medical Society—meets only on call.
Cole County Medical Society—fourth Tuesday of each month.
Cooper County Medical Society—first Monday after the 15th of each month.
Dallas-Hickory-Polk-Dade County Medical Society—first Wednesday of each month.
Dunklin County Medical Society—third Monday of each month.
Franklin-Gasconade-Warren County Medical Society—first Tuesday of each month at the St. Francis Hospital, Washington, at 7 PM.
Grand River Medical Society (Caldwell-Carroll-Livingston, Grundy-Daviess, Harrison, Linn, Mercer, DeKalb)—second Thursday of each month.
Greene County Medical Society—fourth Friday of each month.
Henry County Medical Society—meets only on call.
Howard County Medical Society—meets only on call.
Jackson County Medical Society—March, May, October and December.
Jasper County Medical Society—second Tuesday of each month, September through May.
Jefferson County Medical Society—meets first Wednesday of each month at 7:30 PM.
Johnson County Medical Society—meets only on call.
Lafayette-Ray County Medical Society—second Tuesday of eacb month at 7:30 PM, at the Victory Cafe, Lexington.
Lewis-Clark-Scotland County Medical Society—meets only on call.
Lincoln-St. Charles County Medical Society—fourth Tuesday of each month.
Marion-Ralls-Shelby County Medical Society—third Tuesday of each month, 7:30 p.m.
Mid-Missouri County Medical Society (Phelps-Crawford-Dent-Pulaski-Maries-Laclede)—fourth Thursday of each month.
Miller County Medical Society—meets only on call.
Mineral Area County Medical Society (St. Francois-Iron-Madison-Washington-Reynolds-Ste. Genevieve)—fourth Thursday of each month.
Moniteau County Medical Society—second Thursday of each month.
Montgomery County Medical Society—meets only on call.
Morgan County Medical Society—meets only on call.
North Central Counties Medical Society (Adair-Schuyler-Knox-Sullivan-Putnam)—meets only on call.
Northwest Missouri Medical Society (Nodaway-Holt-Atchison-Gentry-North)—second Thursday of each month.
Ozarks Medical Society (Barry-Lawrence-Stone-Christian-Taney-Newton-McDonald)—second Tuesday of each month, September through June.
Pemiscot County Medical Society—second Thursday of each month.
Perry County Medical Society—second Thursday of each month.
Pettis County Medical Society—third Monday of each month, September through May.
Pike County Medical Society—third Tuesday of each month.
Platte County Medical Society—meets only on call.
St. Louis County Medical Society—second Wednesday of each month, September through May.
St. Louis Medical Society—third Tuesday of each month, October through May.
Semo County Medical Society (Stoddard, New Madrid, Mississippi, Scott)—third Wednesday of each month, September through May.
South Central Counties Medical Society (Howell-Oregon-Texas-Wright-Douglas-Ozark)—fourth Wednesday of each month.
Webster County Medical Society—meets only on call.
West Central Missouri Society (Bates-Cass-St. Clair-Vernon-Cedar)—second Thursday of each month.

Roster of Members by County Societies

(See Instructions on Page 405)

ADAIR COUNTY
(North Central Counties Medical Society)

ANDREW COUNTY MEDICAL SOCIETY
(Savannah 64485)

Baker, Warren C., Savannah
Kelley, Gilbert B., Savannah
Villahermosa, Juanito L., Savannah

ATCHISON COUNTY
(Northwest Missouri Medical Society)

AUDRAIN COUNTY MEDICAL SOCIETY
(Mexico 65265)

Ajans, Z. A., 704 E. Monroe
Boyce, John M., 620 E. Monroe St.
Bradley, William W., Box 47, Centralia 65240
Cottey, John H., 217 E. Jackson
Daut, Donald W., 200 East Monroe
Davis, Leonard L., Jr., #5 Melody Lane
Dwyer, Thomas L., 119 E. Love St.
Ector, Henry J., 521 E. Breckenridge
Ekern, H. Peter, 1415 S. Morris St.
Garcia, Charles L., Mexico
Huq, Md. Nasrul, 212 E. Monroe
Jolly, Benjamin N., 112 N. Clark Ave.
Jolly, William H., 112 N. Clark Ave.
Kallenbach, Glen P., P. O. Box 249
Lankford, Harold D., 117 E. Monroe St.
O'Brien, Harry F., Mexico
Reddin, Patrick, Wallmart Bldg.
Rodes, Ned D., Mexico
Siripipat, Pallop, 222 E. Monroe
Wallace, Edgar S., P. O. Box 471
Wilbers, Raymond H., 113 E. Monroe
Williams, Robert S., P. O. Box 147
Ziegler, Anthony, Jr., 255 Stonewall Jackson Dr., Conroe, Tex. 77301

BARRY COUNTY
(Ozarks Medical Society)

BARTON COUNTY MEDICAL SOCIETY
(Lamar 64759)

Arnold, Herbert M., Lamar
Bickel, Vern T., Lamar
Cain, Alvin R., Lamar
Carroll, Thomas W., P.O. Box 368, Lamar
Gouldner, Edmond, 1103 Broadway, Lamar

BATES COUNTY
(West Central Missouri Medical Society)

BOLLINGER COUNTY
(Mineral Area Medical Society)

BOONE COUNTY MEDICAL SOCIETY
(Columbia 65201)

Adams, Harold D., 401 Keene
Allen, Joseph E., 5813 St. Charles Rd.
Allen, Robert W., 4900 St. Charles Rd.
Allen, William C., 508 W. Briarwood Lane
Almond, Carl H., 807 Stadium Rd.
Anderson, Ivan A., 606 Medavista
Anderson, Philip C., 807 Stadium Rd.
Anderson, Thomas R., Rt. 3, #5 McGregor, La.
Arnold, Richard C., P. O. Box 53
Asel, Norman D., 1502 E. Broadway
Baker, A. Sherwood, 807 Stadium Rd.
Baker, James M., 16 S. 10th St.
Barbee, Charles W., 401 Keene St.
Black, Samuel P. W., 300 S. Glenwood St.
Blackwell, Charles W., 201 W. Broadway
Bourgeois, Curtis, 807 Forest Hill Ct.
Brukardt, Diane, Student Health Service
Bruner, Claude R., Star Rt. B, Box 5-HD, Camdenton 65020
Bumgarner, James E., 1504 E. Broadway
Bumgarner, Roger W., P. O. Box 975
Burns, Thomas W., 310 E. Brandon Rd.
Butt, James H., 800 Stadium
Bynum, William R., P. O. Box 998
Carnahan, Charles E., 3801 Cedar Lane
Chalkley, Judson I., Boone County Hosp.
Chapman, Charles L., 1916 Ridgemont
Cheek, Charles W., 113 W. Broadway
Chiasson, E. Chaille, P. O. Box 1077
Cochran, Donald Q., 1502 E. Broadway
Colwill, Jack M., Countryshire, R.F.D. 5
Cooper, Maurice E., 1000 Wayne Rd.
Cope, James C., 1502 E. Broadway
Craft, George A., 803 Stadium Rd.
Crowley, Wm. J., Jr., 11 S. Williams
Culley, Thomas S., 807 Stadium Rd.
Darnell, Thomas F. B., Doctors Clinic Bldg.
Davis, David, 801 Crestland Ave.
DeLima, Clarence A., 803 Stadium
Denninghoff, James C., 201 W. Broadway
DeWeese, Marion S., 807 Stadium Rd.
Dexheimer, Frank R., 401 Keene
Dexter, James D., 807 Stadium Rd.
Donegan, Judith H., University of Missouri Medical Center
Donegan, William L., Ellis Fischel Cancer Hosp.
Dyer, Gary A., 807 Stadium Rd.
Eggers, George W. N., Jr., 807 Stadium Rd.
Ferneau, James E., 401 Keene
Foote, Jerry E., 1504 E. Broadway
Frazier, Robert Edward, 113 W. Broadway
Fried, Frederick E., 807 Stadium
Frueh, Bartley R., 108 Park Hill Ave.
Fuchs, George J., Jr., 1504 E. Broadway
Galeota, William R., 807 Stadium Rd.
Gammel, George E., Boone County Hospital Laboratory
Garrett, Glen H., 909 University Ave.
Garrotto, Lewis J., 807 Stadium Rd.
Gaunt, William D., 807 Stadium Rd.
Gohil, Jivanlal P., 803 Stadium
Griffin, William T., 807 Stadium Rd.
Hall, David G., 807 Stadium Rd.
Hardwicke, Henry M., Ashland 65010
Harris, Hugh S., Jr., 801 Cowan Dr.
Harris, Robert J., 2505 E. Broadway
Harrison, Winston E., 201 W. Broadway
Hart, William M., 807 Stadium Rd.
Haw, Marvin T., Jr., 1807 Jackson
Heimburger, Richard A., M-349, 807 Stadium
Henry, Lawrence D., P.O. Box 998, 2703 Clark La.
Hickcox, John P., 1504 E. Broadway
Hofmeister, Roger W., 807 Stadium
Hori, Jose M., Community Memorial Hosp., Moberly 65270
Hubbell, Ira G., 302 McNab Dr.
Hueser, James N., 604 W. Broadway
Hyatt, Robert W., 807 Stadium
Ide, Carl H., 600 Laurel Dr.
Jackson, Robert L., 807 Stadium Rd.
James, Elizabeth J. P., 807 Stadium Rd.
James, Ronald C., 610 W. Blvd. South
Johnsgard, Larry S., 807 Stadium Rd.
Johnson, Richard E., Boone County Hosp.
Joseph, Donald J., 807 Stadium Rd.
Kays, Kenneth, 807 Stadium Rd.
Ketizer, Walter Ford, 807 Stadium
Keown, Kenneth K., 807 Stadium Rd.
Kerr, S. Earl, 1308 Fieldcrest
Kilburn, Kaye H., VA Hospital, Rm. 570
Kim, Tchang Man, 807 Stadium Rd.
King, Robert J., 1502 E. Broadway
Kubin, Milford T., 541, 17 Mile Dr., Pacific Grove, Calif. 93950
LaChance, Leopold, 110 W. Sneed, Centralia 65240
Ladenson, Roland P., 16 S. 10th St.
Landhuis, L. R., 113 W. Broadway
Lee, Sung Ae, 807 Stadium
Lee, Yeu-Tsu, L.A.C.-U.S.C. Medical Center, Los Angeles, Calif. 90033
Leech, Charles A., 1504 E. Broadway
Leeper, Sidlee W., 1504 E. Broadway
Lehr, James L., 807 Stadium Rd.
Lewis, Ray B., Rt. #1, Rocheport 65279
Lillard, Stephen B., 807 Stadium
Lim, Jit Kim, 807 Stadium
Lindberg, Donald, Route 4
Litwiller, R. W., 1312 W. Broadway
Lodwick, Gwilym S., 911 La Grange
Logue, John T., 1504 E. Broadway
Lohmar, Roland E., 113 W. Broadway
Lucas, Fred V., 807 Stadium Rd.
McClelland, Bruce A., 807 Stadium
McCluer, Shirley, McHaney Hall, 807 Stadium
McCord, E. Scott, 807 Stadium Rd.
McElroy, Glenn L., 1504 E. Broadway
Marco, Philip J., 1015 College Park
Marienfeld, Carl J., 807 Stadium Rd.
Mayer, William D., 1 Ridgeley Rd.
Metzgar, Marshall T., 807 Stadium Rd.
Meyers, David S., 807 Stadium
Miller, Leroy J., 1502 E. Broadway
Millikan, Larry E., 807 Stadium Rd.
Mitchell, Franklin L., 2208 Danforth Ct.
Mitchell, Lynn D., 401 Keene
Monroe, C. Dean, 803 Stadium Rd.
Montie, Joseph E., 807 Stadium
Moranville, Benedict A., 1504 E. Broadway
Morgan, Philip E., Missouri Regional Medical Program, Lewis Hall
Mosby, Larry D., 107 E. Brandon Rd.
Mullins, Maurice F., 217 W. Broadway
Nieuwenhuizen, Maarten, 803 Stadium Rd.
Nolph, Georgia B., 801 Westport Dr.
Oestreich, Alan, N217 University Medical Center
Orth, Oliver G., 11 S. Williams
Overholser, Milton D., 807 Stadium Rd.
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Payne, John W., 1504 E. Broadway
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Perez-Mesa, Carlos, Ellis Fischel State Cancer Hosp.
Peterson, Vernon J., 807 Stadium
Pfeter, Leland U., 1504 E. Broadway
Pickard, Clarence M., 113 W. Broadway
Pickens, James Milton, 807 Stadium
Pingelton, William B., 113 W. Broadway
Politte, Lenard L., 401 Keene
Prendergast, Thomas J., Jr., 807 Stadium
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Rosenholtz, Mitchell J., 807 Stadium Rd.
Rosenstein, Daniel Lesem, 807 Stadium Rd.
Ross, Gilbert, Jr., 807 Stadium Rd.
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Scheuber, Charles, 1504 E. Broadway
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See, William B., 1504 E. Broadway
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Smith, Joe R., 1506 E. Broadway
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Sosebee, Lee A., 1504 E. Broadway
Spratt, John S., Jr., 105 S. Glenwood Ave.
Spurgeon, Milo J., 404 Edgewood Ave.
Stephenson, Hugh E., Jr., 807 Stadium Rd.
Stewart, Wellington B., Medical Computer Center, 307 Lewis Hall
Stewart, William J., 909 University Ave.
Stoy, Robert P., 201 W. Broadway
Stradford, H. Todd, Clark Hall, 3rd Floor, 807 Stadium
Struessel, Kenneth F., 113 W. Broadway
Sutton, Richard N., 1806 Highridge Dr.
Terry, Boyd E., 807 Stadium
Thomas, Horace E., 1504 E. Broadway
Thomas, Robert M., 113 W. Broadway
Thompson, Ian M., 807 Stadium Rd.
Thomson, James Myron, Jr., Ellis Fischel State Cancer Hospital
Tinsley, John C., Jr., 16 S. Tenth St.
Tsai, Vicente T. NG, 1726-D E. Broadway
Van Dervoort, Robert L., Jr., 401 Keene
Waggoner, Charles M., 201 W. Broadway
Wakerlin, G. E., 3002 Bray Ave.
Walters, John H., 11 S. Williams St.
Walters, Laura, 11 S. Williams St.
Washington, Edward L., 1504 E. Broadway
Watson, Trevor F., 1504 E. Broadway
Weiss, James M. A., 807 Stadium Rd.
Wheeler, Paul C., Univ. of Mo. Med. Center
White, Joseph M., 111 Jesse Hall
Wiggins, Roland L., 408 N. Garth
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Wilson, John E., 401 Keene St.
Wilson, Vernon E., University of Missouri Medical Center
Windmiller, Myrl E., 1504 E. Broadway
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Andres, Edward H., 902 Edmond 64501

° Doctor of Osteopathy.

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Beheler, Edward M., 422 N. 7th St. 64501
Benson, Scott C., 324 N. 6th St. 64501
Berney, Francis J., Kirkpatrick Bldg. 64501
Bristow, Robert B., 1302 Faraon 64501
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Butler, Elza F., 902 Edmond St. 64501
Callman, George, State Hosp. No. 2 64502
Carpenter, George T., 902 Edmond St. 64501
Challener, William A., III, 902 Edmond 64501
Christ, Martin H., 1402 Faraon 64501
Cox, John P., 902 Edmond St. 64501
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Craig, Richard O., 320 Pioneer Bldg. 64501
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Ide, Lucien W., P. O. Box 830 64502
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Lee, Carleton H., 2716 Douglas 64506
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Luechefeld, Frank, 510 Francis 64501
McDaniel, John R., 902 Edmond St. 64501
McDonald, Wallace, 305 N. 8th 64501
McDonald, Wilbur P., 301 N. 8th St. 64501
Maginn, Richard L., 702 Jule St. 64501
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Martin, John N., 1302 Faraon 64501
Minton, Robert S., Rt. 2, 64505
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Morse, Marvin, 2702 Faraon St. 64501
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Muench, Albert H., 620 Francis 64501
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Pifer, Lawrence H., 925 5th Ave. 64501
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Raphel, Jose, 37 Northridge Dr. 64506
Redmond, William, Corby Bldg. 64501
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Roberts, Phyllis Grant, 3314 Linda La. 64506
Rogers, John T., 2502 Ashland Ave. 64506
Rosenthal, Irwin I., State Hospital No. 2 64502
Rost, William B., 2221 N.W. Extension Blvd. 64506
Ryan, John H., 432 Kirkpatrick Bldg. 64501
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Senne, Herbert C., 223 N. 7th St. 64501
Senor, Samuel E., 722½ Francis 64501
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Shevlin, Charles F., 902 Edmond St. 64501
Sklenar, Donald E., 228 Illinois Ave. 64504
Stacy, Winton T., 1215 N. 24th St., 64506
Stallard, Donald J., 902 Edmond St. 64501
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Stuber, Robert R., 1325 Village Dr. 64501
Thompson, F. Gregg, III, 2714 Ashland Ave. 64506
Wadlow, Ernest E., 510 Francis St. 64501
Waggoner, Sharon E., 301 Illinois Ave. 64504
Wallace, Hilen K., 5th and Francis St. 64501
Weed, Randal W., 702 Jule St. 64501
Weinand, Ernest E., 902 Edmond St. 64501
Whitsell, Ora E., 802 N. 23rd St. 64506
Willman, Charles R., 2216 Highly St. 64502
Willumsen, Henry C., 902 Edmond St. 64501
Windsor, David G., Rt. 1, Rosendale 64483

BUTLER-WAYNE-RIPLEY COUNTY MEDICAL SOCIETY

(Poplar Bluff 63901)

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Beecher, Sheldon B., 1517 Rosedale Ave.
Biggs, Fred J., Jr., Kneibert Clinic
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Brookreson, Alton F., 217 Oak St.
Caldwell, Fred, Kneibert Clinic
Camp, Richard V., Jr., Rt. 7, Box 288
Canlas, Emilio M., P. O. Box 1009
Carlson, E. C., 623 Pine
Christy, John P., 623 Pine Blvd.
Cline, Harold H., Piedmont 63957
Dinelli, Frank E., 215 Oak St.
Engelhardt, Robert C., Kneibert Clinic
Fraser, Richard A., 621 Pine
Gernstetter, Sangwill L., P. O. Box 337
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Hoja, W. Alexander, Kneibert Clinic
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Ladyman, George H., 623 Pine St.
Leroux, Gene, Doniphan 63935
Lestmann, Henry E., 202 Plum, Doniphan 63935
Loughead, John R., 1201 Lurlyn Dr.
McLane, Jerry F., 330 N. 2nd St.
McPheeters, James W., Sr., 330 N. 2nd St.
Macauley, Bernard J., 215 Oak St.
Markel, Arthur D., Kneibert Clinic
May, Albert L., Jr., 330 N. 2nd St.
Miller, David V., Kneibert Clinic
Morgan, Marvin W., 2710 Shady Lane
Parker, Arthur C., Jr., Kneibert Clinic
Plunkett, Littleton J., Jr., 330 N. 2nd
Ramirez, Ricardo M., Kneibert Clinic
Raper, Charles A., 330 N. 2nd St.
Reddy, A. N., 623 Pine Blvd.
Reddy, Sarvotham K., 623 Pine Blvd.
Robertson, William D., Poplar Bluff
Ruff, T. Eugene, Kneibert Clinic
Shriver, Ronald G., 623 Pine Blvd.
Tiffany, Delbert E., Rt. 2, Box 42
Till, Bennie N., 2030 Meadows
Tinsley, Austin R., 2nd and Oak
Traxel, William Louis, 623 Pine Blvd.
Tuma, Arthur T., 215 Oak St.
Turner, James H., 217 Oak St.
Turner, Kirby L., 623 Pine
Turner, William F., 217 Oak St.
Varma, D. K., 2506 N. Main
White, Barry B., 330 N. 2nd St.
Wood, Tom, Kneibert Clinic

CALDWELL COUNTY

(Grand River Medical Society)

CALLAWAY COUNTY MEDICAL SOCIETY

(Fulton 65251)

Arana, Victor A., Callaway Bank Bldg.
Brown, John J., 101 E. 6th St.
Brown, Katherine S., 1304 Vine St.
Cremer, William J., State Hosp. No. 1
Domke, Herbert R., 221 W. High, Jefferson City 65101
Durst, Henry, 610 Court St.
Espinosa, Tomas, Fulton State Hospital
Gish, Rutledge, 5 E. 5th St.
Groce, George, 820 Jefferson St.
Hill, James E., 820 Jefferson St.
Jackson, Vernon B., State Hosp. No. 1
Oshourn, Richard A., 820B Jefferson
Peterson, Donald B., State Hosp. No. 1
Ritterbusch, James K., State Hosp. No. 1
Sydow, Henry A., 10 W. 6th
Wood, George F., 614 Market St.

CAMDEN COUNTY

Carnell, B. M., Camdenton 65020 (Member Mid-Missouri County Medical Society)
Garrison, T. W., Camdenton 65020 (Member Mid-Missouri County Medical Society)
Holley, Donald B., Camdenton 65020 (Member Mid-Missouri County Medical Society)
Wayland, Thomas A., Camdenton 65020 (Member Cole County Medical Society)

CAPE GIRARDEAU COUNTY MEDICAL SOCIETY

(Cape Girardeau 63701)

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Ashley, Hugh V., P. O. Box 618
Bahn, Charles F., 801 S. Mount Auburn Rd.
Barnes, Seth S., 1854 Broadway
Blankenship, Dale M., Doctor's Park
Bowman, William K., 14 Doctor's Park
Burford, Edwin K., Jr., P.O. Box 615
Campbell, Edward D., 937 Broadway
Chapman, Jean A., 801 S. Mount Auburn Rd.
Cochran, Jo R., 24 N. Sprigg St.
Coulson, Forest H., 19 Doctor's Park
Cozean, Charles H., Jr., 937 Broadway
Crowe, John T., 937 Broadway
Dinkins, James A., 36 Doctor's Park
Downey, Jon Patrick, 210 Christine
Edwards, Donald E., 937 Broadway
Elrod, Dennis B., 211 N. Sprigg St.
Essmyer, Joseph K., 937 Broadway
Herbert, Charles T., 824 Good Hope St.
Holcomb, John K., 24 N. Sprigg St.
Horn, Paul C., Doctor's Park
Hoxworth, Gerald M., 313 Woodhill Rd., Columbia 65201
Hunt, Robert S., 10 Doctors' Park
Jaeger, Joseph N., 208 S. High St., Jackson 63755
Johnson, Earl W., 937 Broadway
Johnson, Ernest D., 937 Broadway
Jones, David N., 210 Christine
Jung, J. Marshall, Box 417, Illmo 63754
Kasten, Melvin C., 1209 Sailer Circle
Keim, John H., 1845 Woodlawn
Kinder, James A., 937 Broadway
Kinder, Jerry L., Doctors' Park
Koldys, Kenneth, Doctors' Park
Kratz, Paul E., 2560 Gordonville Rd.
Lovinggood, Thomas A., 2505 Allendale
McDonald, Eugene F., 125 Court St., Jackson 63755
McGinty, Charles P., 10 Doctors' Park
Magaletta, George E., 937 Broadway
Nunnelly, Gordon M., 1924 Broadway
Oehler, William F., 213 N. Sprigg St.
Otto, Thomas G., 1912 Broadway
Parsons, D. LeRoy, 35 Doctors' Park
Rapp, Harold B., 1011 N. Henderson St.
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Ridings, Harold D., 937 Broadway
Ritter, C. John, 801 S. Mount Auburn Rd.
Ritter, Carl F., 937 Broadway
Ritter, Raymond A., 1257 Rockwood Dr.
Ritter, Raymond A., Jr., 1912 Broadway
Roberts, Perry, Doctors' Park
Seabaugh, L. R., Doctors' Park
Seabaugh, William O. L., 24 N. Sprigg St.
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Sparkman, Thomas C., 601 N. Kingshighway
Spence, Paul A., 35 Doctors' Park
Stewart, Wendell K., 723 North Sunset
Talbert, Clifford R., 801 S. Mount Auburn Rd.
Terry, James W., Jr., #18 Doctors' Park
Tygett, Glenn J., 834 Alta Vista Dr.
Tygett, Joseph N., 17 Doctors' Park
Weeks, George R., 937 Broadway
Wilson, Charles F., 714 Broadway
Wolff, Paul G., 1819 Broadway

CARROLL COUNTY

(Grand River Medical Society)

CASS COUNTY

(West Central Missouri Medical Society)

CEDAR COUNTY

(West Central Missouri Medical Society)

CHARITON-MACON-MONROE-RANDOLPH COUNTY MEDICAL SOCIETY

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[°] Doctor of Osteopathy.

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Barnett, Floyd A., Paris 65275
Campbell, James E., Macon 63552
Chute, W. Deward, Moberly 65270
Cohrs, Clarence C., Moberly 65270
Collins, Gretchen D., Macon 63522
Dreyer, Philip V., Huntsville 65259
Eggleston, Donald E., Macon 63552
Fleming, J. Will, Jr., Moberly 65270
Fleming, Thomas S., Moberly 65270
Harms, Florian L., Salisbury 65281
Huber, Lasley E., Moberly 65270
Hudson, G. R., Moberly 65270
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Stuart, Daniel D., Brunswick 65236
Tompson, Robert V., 423 E. Logan, Moberly 65270
Young, Robert H., Moberly 65270

CHRISTIAN COUNTY
(Ozarks Medical Society)

CLARK COUNTY
(Lewis-Clark-Scotland County Medical Society)

CLAY COUNTY MEDICAL SOCIETY

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Dernoncourt, John E., Smithville 64089
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Fischer, Edward H., Suite 415, 2929 Baltimore Ave., Kansas City 64108
Flanders, Virgil E., 2022 W. 91st St., Leawood, Kan. 66206
Fotopoulos, Chris K., 201 E. 21st Ave., N. Kansas City 64116
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Hodge, Robert H., 2029 Burlington Ave., Kansas City 64116
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Ise, Frank H., 2030 Swift Ave., N. Kansas City 64116
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Kirkland, Jerry A., 8630 N. Oak Trafficway, Kansas City 64155
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Lanning, R. James, 2700 Hospital Dr., N. Kansas City 64116
Latimer, Walter N. A., 5140 N.E. Antioch Rd., Kansas City 64119
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McCluggage, Newton C., 2700 Hospital Dr., Kansas City 64116
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Pileggi, Felix A., 405 E. 19th St., N. Kansas City 64108
Purcell, P. L., Smithville 64089
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Schutz, John P., 1236 Jesse James Rd., Excelsior Springs 64024
Slaughter, Carl R., 1001 N. Woodland, Kansas City 64118
*Smith, Charles H., 5008 N.E. 45th Terr., Kansas City 64117
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Sportsman, Weldon L., 410 N.E. 68th St. North, Kansas City 64118
Stratman, Clarence A., 6002-A North Antioch Rd., Kansas City 64119
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Waterman, Franklin M., Liberty 64068
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Workman, Charles E., 2700 Hospital Dr., N. Kansas City 64116
Wright, Earl J., 8196 N.W. Kirkwood Dr., Kansas City 64151

CLINTON COUNTY MEDICAL SOCIETY

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Ozenberger, Larry A., Plattsburg 64477
Spalding, Wilber B., Plattsburg 64477
Sweiger, James H., Plattsburg 64477

COLE COUNTY MEDICAL SOCIETY
(Jefferson City 65101)

Allan, James E., 2009 E. McCarty
Belden, Edgar A., 2124 Lowell
Bowe, Edwin Earl, 915 Leslie Blvd.
Bradley, William B., 731 E. High
Bregant, Robert E., 1505 Southwest Blvd.
Busby, William E., 917-A Leslie
Clark, Kendall A., 226 E. Dunklin
Cooper, Charles W., 423 Cherry St.
Courter, Larry P., 1505 Southwest Blvd.
Cox, William A., 812 Swifts Highway
Davisson, Walter F., Jr., 913 Leslie Blvd.
Doerhoff, Adelia, Shepherd Hills Dr.
Doerhoff, Allan, Shepherd Hills Dr.
Exon, C. Stuart, 1505 Southwest Blvd.
Files, James B., Charles E. Still Hospital
Fullgrabe, E. A., 1904 Missouri Blvd.
Garner, Lynn M., 403 Meier Dr.
Garner, Royal S., 1804 Southwest Blvd.
Gentry, Merritt L., P.O. Box 570
*Giffen, L. E., 420 E. High
Gordon, James S., 915 Leslie Blvd., Suite E.
Guhleman, Henry V., Jr., 506 E. High
Gurnee, Landon H., 1431 Southwest Blvd.
Handler, Fred P., 614 Boonville Rd.
Hauser, Robert J., 1431 Southwest Boulevard
Kanagawa, Harold K., 701 W. High
Kelly, Marshall W., 612 E. High St.
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McCaffree, Mary K., 1505 Southwest Blvd.
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Matthews, John I., 701 W. High
Maxey, Hugh W., 518 Mesa
Meier, Francis X., 1913 Hayselton Dr.
Meinershagen, Charles W., 111 Forest Hill
Moseley, Otis O., Box 248, Osage Beach 65065
*Nemer, Robert J., Vienna 65582
Ossman, Julian A., 2407 W. Main
Robb, Harold Phillip, 722 Jefferson
Russell, Joseph P., Division of Health
Ryan, Thomas J., 1433 Southwest Blvd.
Sanders, Jack S., 1505 Southwest Blvd.
Schmidt, J. H., 824 Southwest Blvd.
Schokker, Johannes, 2009 E. McCarty
Scott, E. David, 2009 E. McCarty
Sennott, John S., 1431 Southwest Blvd.
Shull, G. Donald, 1431 Southwest Blvd.
Sicat, A. V., 1433 Southwest Blvd.
Sicat, Luzviminda F., 414 Ladue Rd.
Siu, Kenneth K. C., 915 Leslie Blvd.
Stauffer, Harry B., 830 Boonville Rd.
Stricker, Harold C., 1431 Southwest Boulevard
Sugarbaker, Everett D., 503 E. High St.
Summers, Joseph S., Jr., 515 E. High St.
Tanner, Robert H., 1505 Southwest Blvd.
Taylor, Leon A., 1104 W. Main
Tietjen, Frederick O., 1433 Southwest Blvd.
Van Vranken, Eugene E., 221 W. High
Wallace, John K., II, 220 Ridgeway Dr.
Watts, Byron E., 1505 Southwest Blvd.
Wayland, Thomas A., Box 239, Camdenton 65020
Werth, Joseph, 917 Leslie Blvd.
Winegar, Alvon C., 1431 Southwest Boulevard

COOPER COUNTY MEDICAL SOCIETY
(Boonville 65233)

Abele, Wm. A., 329 Main
Avery, Willard B., 329 Main St.
Diekroeger, Manuel L., Route 1

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* Doctor of Osteopathy.

Hata, Daikichi, 329 Main St.
Humphreys, Edward T., 329 Main St.
Stuart, Byron M., 329 Main St.
Winn, George W., 329 Main St.

CRAWFORD COUNTY
(Mid-Missouri County Medical Society)

DADE COUNTY
(Dallas-Hickory-Polk-Dade Medical Society)

DALLAS-HICKORY-POLK-DADE COUNTY MEDICAL SOCIETY

Barnett, Charles H., Bolivar 65613
Bauer, Harold A., 3823 S. Camphell, Springfield 65804
Griffin, Evelyn, Buffalo 65622
Griffin, Olin A., Jr., Buffalo 65622
Harrell, Henry J., Rt. 1, Box 535, Summerfield, Fla. 32691
Kahler, Monte R., Bolivar 65613
Koon, Ben H., Bolivar 65613
McCraw, Doyle C., Bolivar 65613
McNeel, Lee A., Jr., Greenfield 65661
Robinson, George G., Humansville 65674

DAVIESS COUNTY
(Grand River Medical Society)

DEKALB COUNTY
(Grand River Medical Society)

DENT COUNTY
(Mid-Missouri County Medical Society)

DOUGLAS COUNTY
(South Central Counties Medical Society)

DUNKLIN COUNTY MEDICAL SOCIETY

Benson, Leo J.. Jr.. Kennett 63857
Cash, Charles R.. Kennett 63857
Croom, Dorwyn W., Malden 63863
Dunmire, George Q., Kennett 63857
English, Wallace D., Cardwell 63829
Garrison, Norman A., Jr., General Delivery, Corinth, Miss 38834
Hopkins, Florian G., Gideon 63848
Legan, John K., Kennett 63857
Miltenberger, Paul C., Kennett 63857
Morehead, William E., Malden 63863
Palenske, Robert L., Hornersville 63855
Peck, Chester R., Jr., Kennett 63857
Pu, Pin H., P.O. Box 827, Kennett 63857
Santos, Romeo I., Kennett 63857
Sisler, Maynard Lee, 217 College, Kennett 63857
Tarver, Quinton, Kennett 63857
Wilson, Loys C., Kennett 63857
Zimmerman, Joe A., Kennett 63857

FRANKLIN-GASCONADE-WARREN COUNTY MEDICAL SOCIETY

Aulenbacher, Carl E., 1509 E. 3rd Parkway, Washington 63090
Baker, Donald L., Union 63084
Bonney, Samuel C., Washington 63090
Bozzo, Raymond J., Washington 63090
Brenner, Paul A., Owensville 65066
Crawford, Robert M., Sullivan 63080
de la Torre, John J., Sullivan 63080
Eisenmann, Benjamin P., New Haven 63068
Eyermann, H. Walter, Warrenton 63383
Farrell, S. L., Washington 63090
Hoelscher, Harold F.. Warrenton 63383
Mays, Frank G., Washington 63090
Mitchell, Thomas J., St. Clair 63077
Moellenhoff, Robert W., Washington 63090
Murney, Joseph A., Washington 63090
Post, John P.. Washington 63090
Richardson, George A., Union 63084
Richardson, William R., Union 63084
Royse, Roy P., Sullivan 63080
Ryan, John B., Washington 63090
Schmidt, Charles A., Gerald 63037
Shea, James G., Washington 63090
Sincox, Charles H., 205 Elm, Washington 63090
Steinbeck, Herbert D., IBM Corp., Neighhorhood Rd., Kingston, N. Y. 12401
Strehlman, Benjamin G., Union 63084
Workman, George M., Hermann 65041

GASCONADE COUNTY
(Franklin-Gasconade-Warren County Medical Society)

GENTRY COUNTY
(Northwest Missouri Medical Society)

GRAND RIVER MEDICAL SOCIETY
(Caldwell-Carroll-Livingston-Grundy-Daviess-Harrison-Linn-Mercer-DeKalb Counties)

Allen, E. Warren, Carrollton 64633
Atcheson, Windsor B., Trenton 64683
Bales, Eugene L., Carrollton 64633
Bohnsack, Ralph W., Brookfield 64628
Brennan, Raymond J., Chillicothe 64601
Broyles, Watkins A., Bethany 64424
Cofer, T. N., P.O. Box 905, Chillicothe 64601
Conrad, Joseph, P.O. Box 905, Chillicothe 64601
Cross, Albert D., Trenton 64683
Daley, Frank R., Hamilton 64644
Dixon, John R., Brookfield 64628
Dowell, J. Larry, Pattonsburg 64670
Duffy, Oliver F., Trenton 64683
Ellsworth, Willard, Cainsville 64632
Fair, William L., Chillicothe 64601
Fuson, William A., Trenton 64683
Gale, Joseph F., Chillicothe 64601
Galvez, Sisenande P., Jr., 1500 N. Kansas, Marceline 64658
Gary, George, Marceline 64658
Gearhart, Merriam, Bethany 64424
George, Theodore, 1500 N. Kansas, Marceline 64658
Gilliland, Charles E., Cameron 64429
Howell, Billy D., Brookfield 64628
Kimberlin, Herhert C., Trenton 64683
McArtor, Thomas R., Browning 64630
Magill, Joseph S., Milan 63556
Mandler, George, Chillicothe 64601
Nixon, Edward E., Gallatin 64640
Platz, John H., Carrollton 64633
Rose, John F., 1024 Grandview, Chillicothe 64601
Ryan, David L., 600 E. 9th, Trenton 64683
Smith, Robert W., 618 West Locking, Brookfield 64625
Staton, R. Hamilton, Carrollton 64633
Szymanski, Stanley R., 329 N. Rollins, Macon 63552
Trinidad, Hermanito R., 913 Webster, Chillicothe 64601
Vandiver, Virgil D., Chillicothe 64601
Vinyard, Jack L., St. John's Medical Center, 2727 McClelland Blvd., Joplin 64801
Wilson, Fred K., Winston 64689
Yoon, Jin Soo, 103 11th, Chillicothe 64601

GREENE COUNTY MEDICAL SOCIETY
(Springfield)

Allen, Jerry H., 1211 S. Glenstone St., 65804
Allison, James B., 2200 E. Sunshine 65804
Ancheta, Apolinario A., 1715 Boonville 65803
Anthony, Dallas D., Rm. 403, Professional Bldg., 609 Cherry 65806
Ash, Charles J., Professional Bldg., 65806
Ashley, Thomas E., 1211 S. Glenstone St. 65804
Atkinson, Thomas E., Jr., 609 E. Cherry St. 65806
Auner, Cecil R., 600 S. Glenstone St. 65802
Back, Donald K., 1211 S. Glenstone St. 65804
Bailey, Alan B., 609 Cherry 65806
Baldwin, Richard, 600 S. Glenstone St. 65802
Barnhill, Floyd R., 600 S. Glenstone 65802
Beard, R. Wheatley, 2 Mohave Dr., North Little Rock, Ark. 72116
Beisner, Donald H., 600 S. Glenstone 65802
Benson, Ronald G., 404 E. Battlefield 65807
Bentley, John D., 419 Professional Bldg. 65806
Berry, Paul T., 1740 S. Glenstone 65804
Blades, Ross D., 1211 S. Glenstone St. 65804
Bonebrake, MacDonald, Rm. 304, Professional Bldg., 609 Cherry 65806
Boone, Martin H., Jr., Rt. 2, Box 315, 65802
Borja, Egbert R., Lynn & Robberson 65802
Brent, Lanny R., 1504 N. Rohberson 65803
Broaddus, Loren, 1550 E. Sunshine 65804
Brown, David W., Professional Bldg. 65806
Brown, James T., 2222 E. Berkeley 65804
Brown, Lyman D., 604 Empire Bldg. 65806
Burkey, Jordan W., Professional Bldg. 65806
Busiek, Erwin F., Rm. 319, Professional Bldg., 609 Cherry 65806
Busiek, Paul J., 1717 E. Grand 65804
Busiek, Urban J., Professional Bldg. 65806
Callaway, Guy D., 1155 S. Delaware St. 65804
Callaway, Guy D., Jr., 1211 S. Glenstone St. 65804
Carr, Phillip W., 1211 S. Glenstone 65804
Cheek, J. William, Rm. 419, 609 Cherry 65806
Christy, Raymond A., Jr., 1211 S. Glenstone St. 65804
Clarke, Michael J., Rm. 116, Professional Bldg., 609 Cherry 65806
Clary, William F., 1636 S. Glenstone St. 65804
Clawson, James W., Professional Bldg. 65806
Clayton, Edgar L., Professional Bldg. 65806
Cochran, Thomas E., Jr., 2423 Brentwood Blvd. 65804
Coller, Frederick C., 2433 Marlan St. 65802
Conrad, Raymond C., 609 Cherry St. 65806
Cook, James R., 2333 E. Glenwood 65804
Cooper, C. Wesley, 1211 S. Glenstone 65802
Cordonnier, James K., 1550 E. Sunshine 65804
Corry, Francis M., 1211 S. Glenstone 65804
Coscia, Robert, 1446 N. Robberson 65802
Crane, John Bruce, 1211 S. Glenstone 65804
Crawford, Oral B., Rm. 229, Professional Bldg., 609 Cherry 65806
Creighton, John C., Suite 501, 1443 N. Robberson 65802
Crostwait, Ed L., 1305 Battlefield 65804
Cunningham, Darral D., 1715 Boonville Ave. 65803
Danielsson, Ernst P., 3324 Redhud Ln. 65804
Dillard, Erin M., Professional Bldg. 65806
Dills, Joseph N., 1554 S. Campbell 65804
Dolan, Daniel L., Professional Bldg. 65806
Domann, Darrel D., Professional Bldg. 65806
Duncan, Robert D., 1534 E. Sunshine 65804
Edison, John M., 600 S. Glenstone 65802
Elkadi, Ahmed, 315 Professional Bldg. 65806
Elkins, Ronald F., 2830 E. Glenwood 65804
Ellis, Francis J., Professional Bldg. 65806
Ellis, Harry L., Professional Bldg. 65806
Emery, Frank E., 1550 E. Sunshine 65804
Evans, Ezra L., Jr., 2457 E. Barataria 65804
Farthing, Gene W., 1636 S. Glenstone St. 65804
Ferguson, John L., 1550 E. Sunshine 65804
Ferguson, John P., Jr., 609 Cherry 65806
Ferrell, Thomas E., Jr., 1550 E. Sunshine Blvd. 65804
Fink, Roger L., 1423 N. Jefferson 65802
Fitch, C. H. Max, 1711 Boonville Ave. 65803
Fogerson, Virginia L., 900 S. Pickwick 65804
Fogle, Philip R., 1636 S. Glenstone 65804
Francis, William C., 600 S. Glenstone St. 65802
Gaska, Walter J., 1211 S. Glenstone 65804
Gentry, Michael A., 1211 S. Glenstone 65804
Gerdes, John A., St. John's Hospital 65804
German, Walter A., Jr., 1211 S. Glenstone St. 65802
Giddings, Frank C., Burge Protestant Hosp. 65803
Giffin, James M., Professional Bldg., 65806
Glover, Jack F., 1550 E. Sunshine 65804
Gorelick, David F., 1041 Linwood Terr. 65804
Gose, Don F., 1550 E. Sunshine 65804
Haen, Charles J., 1630 N. Jefferson 65803
Hall, David W., Rt. 2, Rogersville 65742
Hall, Durward G., 2442 S. Fremont 65804
Hamburg, Frederic L., 600 S. Glenstone 65802
Hanan, Ernest B., 724 E. Kingsbury 65804
Hanss, Armand W., 3500 Cherry 65804
Harmon, Ben C., 1211 S. Glenstone St. 65804
Harrison, Stratton W., Professional Bldg. 65806
Harvey, Harold D., 2030 S. National 65804
H'Douhler, Charles E., Professional Bldg. 65806
H'Douhler, Francis T., Jr., Professional Bldg. 65806
H'Doubler, Peter B., 609 Cherry St., Suite 114 65806
Herfkens, Kenneth D., 609 Cherry, 65806
Hills, Joseph E., 2917 Natural Bridge 65804
Holland, Robert D., 1211 S. Glenstone 65804
Hollis, Richard W., Professional Bldg. 65806
Holmes, Daniel E., Route 9, Box 191 65804
Holmes, David R., 1636 S. Glenstone St. 65804
Hoover, H. Lee, Jr., 1330 E. Walnut St. 65802
Horton, James D., Professional Bldg. 65806
Hubbard, Sally L., 901 S. National 65802
Huewe, Douglas A., 609 Cherry 65806
Hulstra, Johannes F. W., 1211 S. Glenstone St. 65804
Ippensen, John H., 600 S. Glenstone 65802
Isaac, Anita M., 1423 N. Jefferson 65802
Ivy, Henry B., 600 S. Glenstone St. 65802

° Doctor of Osteopathy.

Jameson, James E., Rm. 118, Professional Bldg., 609 Cherry 65806
Jobe, Charles L., Jr., 1211 S. Glenstone 65804
Johnson, Fritz M., 609 Cherry 65806
Johnson, George A., 229 Professional Bldg. 65806
Johnson, Joseph C., Jr., 1211 S. Glenstone 65804
Johnson, Warford B., Rm. 330, Professional Bldg., 609 Cherry 65806
Johnson, William F., Professional Bldg. 65806
Johnston, Joseph L., 2855 Southern Hills Blvd. 65804
Jones, Harold L., 1550 E. Sunshine 65804
Key, James S., Rm. 415, Professional Bldg., 609 Cherry, 65806
Kipfer, Robert E., 817 Mohave Dr., Pontiac, Ill. 61764
Klingner, George M., 1630 N. Jefferson St. 65803
Klingner, George M., Jr., 1630 N. Jefferson 65803
Knabb, Kenneth E., 1630 N. Jefferson St. 65803
Kolze, Vernon W., 600 S. Glenstone 65802
Krahn, Henry C., 1423 N. Jefferson 65802
Langston, Walter R., Professional Bldg. 65806
Le Fevre, Philip J., 2030 S. National 65804
Leidinger, Karl J., Republic 65738
Lemmon, George B., Prof. Bldg. 65806
Lewis, Noel R., 1423 N. Jefferson Ave. 65803
Litton, Lyle D., Cox Medical Center 65803
Lockhart, Charles E., Professional Bldg. 65806
Loeb, Richard H., 1211 S. Glenstone 65804
Lorenc, Ernest, Professional Bldg. 65806
Lovett, Robert L., 2850 Versailles 65804
Lowe, Horace A., Jr., 114 Professional Bldg. 65806
Lurie, Harold H., 600 S. Glenstone St. 65802
McAlhany, Howard J., 609 Cherry St. 65806
McKinsey, John J., Professional Bldg. 65806
McLaughlin, Richard D., 117 Professional Bldg. 65806
Maddux, William P., Professional Bldg. 65806
Maher, Robert W., Professional Bldg. 65806
Mantell, Jack M., 1550 E. Sunshine 65804
Maple, Francis M., 1211 S. Glenstone St. 65804
Menchetti, Don E., 1630 N. Jefferson Ave. 65803
Mentgen, Carl N., 1550 E. Sunshine 65804
Michael, Harvey R., 1211 S. Glenstone 65804
Milne, Jay L., 609 Cherry St. 65806
Moore, De Armond, 1211 S. Glenstone 65804
Morton, Paul C., 1508 E. Stanford 65804
Moseley, F. Thomas, 609 Cherry St. 65806
Napper, Marvin L., Professional Bldg. 65806
Neu, Leo T., Jr., 3008 Carlisle Circle 65804
Olson, Elbert R., 609 Cherry 65806
Overend, Don S., 1211 S. Glenstone St. 65804
Palcheff, Chris L., 1636 S. Glenstone St. 65804
Park, William I., Jr., Professional Bldg. 65806
Parlato, George S., 107 Professional Bldg. 65806
Penninger, William H., 600 S. Glenstone St. 65802
Peterson, Stanley S., 1211 S. Glenstone St. 65804
Podrecca, Guido I., Professional Bldg. 65806
Powell, Edwin M., Professional Bldg. 65806
Prater, Bill G., Professional Bldg. 65806
Pruett, Paul L., Professional Bldg. 65806
Quinn, Paul S., 1423 N. Jefferson 65802
Rainwater, Elmer H., Professional Bldg. 65806
Rao, V. Padmanabha, 1636 S. Glenstone 65804
Rigney, Levi M., 505 Woodruff Bldg. 65806
Rinker, Carl T., Jr., 2930 S. Glendale 65804
Rising, Dean R., 1211 S. Glenstone 65804
Robbins, Judy C., 2435 E. Cambridge 65804
Robinson, Gary L., 404 E. Battlefield 65807
Russell, Earl D., 1503 S. Glenstone St. 65804
Sala, Jose M., 1423 N. Jefferson Ave. 65803
Sammon, T. James, 609 Cherry 65806
Sauer, Paul E., Route 11, Box 2325 65804
Scanlon, Robert C., 1711 Boonville St. 65803
Schaeffer, Edward M., 600 S. Glenstone St. 65802
Schreiber, Norman J., 642 S. Hickory Pl. 65804
Schroff, Carle H., 1630 N. Jefferson Ave. 65803
Schwartz, Eugene J., Professional Bldg. 65806
Shackter, Bruce I., 609 Cherry, Room 406, 65806
Shane, Ramon A., Rm. 404, Professional Bldg., 609 Cherry 65806
Shelton, R. Wayne, 1211 S. Glenstone 65804
Siceluff, Joseph G., Rm. 224, Professional Bldg., 609 Cherry 65806
Silsby, Don J., Rm. 401, Professional Bldg., 609 Cherry 65806
Silsby, Harry D., Professional Bldg. 65806
Simpson, Albert P., 1636 S. Glenstone 65804
Simpson, Emerson L., 1630 N. Jefferson Ave. 65803
Smith, C. Souter, 1223 S. Kenwood 65804
Snead, William H., Jr., 609 Cherry 65806
Spalding, David L., Professional Bldg. 65806
Sponenberg, Don E., 1211 S. Glenstone 65804
Stewart, Robert B., 600 S. Glenstone St. 65802
Stewart, R. Wendell, Rm. 219, Professional Bldg., 609 Cherry 65806
Stubblefield, Wayne, 2740 S. Glenstone 65804
Stufflebam, Robert E., 2323 E. Rosebrier 65804
Sturtevant, Harwood N., Rm. 403, Professional Bldg., 609 Cherry 65806
Sullivan, Dan T., 609 Cherry 65806
Sundstrom, Frank D., 1211 S. Glenstone St. 65804
Suva, Morfeo M., 440 S. Market 65802
Sweeney, Thomas P., Professional Bldg. 65806
Tarrasch, Ernest L., 1636 S. Glenstone St. 65804
Taylor, William E., Southwest Missouri State College 65802
Tendai, Mark M., 1630 N. Jefferson 65803
Terry, James F., 609 Cherry 65806
Thomasson, David D., 600 S. Glenstone St. 65802
Tillman, Walter W., Jr., Rm. 229, Professional Bldg., 609 Cherry 65806
Tombridge, Thomas L., Professional Bldg. 65806
Trotter, W. Yates, 1243 E. Catalpa 65804
Tsang, John L. K., 1636 S. Glenstone St. 65804
Turner, Glenn O., Professional Bldg. 65806
Vensel, Lee H., 600 S. Glenstone St. 65802
Waddell, Kenneth E., 1211 S. Glenstone St. 65804
Wakeman, J. Newton, 600 S. Glenstone St. 65802
Wakeman, J. Newton, Jr., 406 Professional Bldg. 65806
Walker, William M., Professional Bldg. 65806
Wantuck, Donald K., 1211 S. Glenstone 65804
Warren, William H., 1423 N. Jefferson 65802
Warres, Herbert L., 2614 Englewood Rd. 65804
Waterfield, Jim R., 1211 S. Glenstone St. 65804
Webb, Leslie R., Jr., 1243 E. Loren 65804
White, R. Ned, 404 E. Battlefield 65807
Whitlock, C. Courtney, Professional Bldg. 65806
Williams, John W., 600 S. Glenstone St. 65802
Williams, John W., Jr., 1227 Roanoke St. 65804
Wilson, Roy E., 1211 S. Glenstone St. 65804
Winsky, Arlen D., 226 Professional Bldg. 65806
Wise, Gordon F., Rm. 229, Professional Bldg., 609 Cherry 65806
Wittmer, Samuel C., 600 S. Glenstone St. 65802
Wong, George, Jr., 2030 S. National 65804
Wooldridge, Wilfred E., Professional Bldg. 65806
Wyrsch, Leo M., Jr., 304 Professional Bldg. 65806
Yancey, Daniel L., 1211 S. Glenstone St. 65804
Zahn, Robert L., Professional Bldg. 65806

GRUNDY COUNTY
(Grand River Medical Society)

HARRISON COUNTY
(Grand River Medical Society)

HENRY COUNTY MEDICAL SOCIETY

Bradshaw, William D., Clinton 64735
Hollingsworth, Ray S., Clinton 64735
Hughes, Shelby B., Clinton 64735
Jones, Edna M., Clinton 64735
King, Richard H., Clinton 64735
Smith, James O., Clinton 64735
Smith, William J., Windsor 65360
Wetzel, Gus S., Clinton 64735

HICKORY COUNTY
(Dallas-Hickory-Polk-Dade County Medical Society)

HOLT COUNTY
(Northwest Missouri Medical Society)

HOWARD COUNTY MEDICAL SOCIETY

Dean, Francis D., Fayette 65248
Leech, Maurice P., Fayette 65248
Marshall, William G., Glasgow 65254
Shaw, William J., Jr., Fayette 65248

HOWELL COUNTY
(South Central Counties Medical Society)

IRON COUNTY
(Mineral Area County Medical Society)

JACKSON COUNTY MEDICAL SOCIETY
(Kansas City)

Aaron, George A., 1515 W. Truman Rd., Independence 64050
Abaqueta, Gamaliel P., 729 E. 70th 64131
Abella, Bienvenido Z., 6400 Prospect 64132
Abercrombie, Keith J., 6700 Troost 64131
Abrams, Bernard M., 751 E. 63rd St., 64110
[°]Ackley, Edward J., 3917 N. Cleveland 64117
Adelman, Arthur, 601 E. 63rd St. 64110
Adler, Federico, 601 E. 63rd St. 64110
Agee, Loren G., 11201 Colorado 64137
Aks, Daniel, 751 E. 63rd St. 64110
Alberg, Marvin R., 3525 N.W. 60th Terrace 64151
Alderman, Thomas F., 7540 Troost 64131
Allebach, H. K., 6400 Prospect 64132
Allen, Robert E., 4320 Wornall Rd. 64111
Alsop, Webb S., Jr., 6400 Prospect 64132
Altomare, Edward P., 1030 W. 65th 64113
Ames, Mary B., 2220 Holmes 64108
Ammatelli, Francis J., 7546 Troost St. 64131
Amoury, Raymond A., 24th & Gillham Rd. 64108
Anderson, Raymond B., 24th & Gillham Rd. 64108
Anderson, Richard W., 1001 Romany Rd. 64113
Andrus, Bailey C., 4320 Wornall Rd. 64111
Arbab, Ali A., 751 E. 63rd 64110
Arms, Arnold V., 4320 Wornall Rd. 64111
Arnold, John D., 2322 Holmes 64108
Arribas, Romeo F., 1212 10th St., Blue Springs 64015
Aschman, Theodore H., 8740 Brooklyn 64132
Ashby, Jennifer D., 24th & Cherry 64108
Ashcraft, Keith W., 510 Medical Plaza 64111
Asher, A. Graham, 4706 Broadway 64112
Ashley, John T., 24th & Cherry 64108
Asnani, Mithlesh G., 825 Euclid 64124
Atwell, Floyd C., 4320 Wornall Rd. 64111
Averill, Keith H., 2316 E. Meyer Blvd. 64132
Ayotte, Nancy C., 5519 Crestwood Dr. 64110
Baer, Alvin J., 751 E. 63rd St. 64110
Baker, Philip J., 11440 E. 47th St. 64133
Balanoff, Arnold Z., 601 E. 63rd 64110
Ballard, V. Bryce, 4320 Wornall Rd. 64111
Bankuti, Ferenc, 6400 Prospect 64132
Bare, Chester I., Jr., 7013 Lake Shore Dr. 64133
Barelli, Pat A., 4177 Broadway 64111
Barloon, James H., 6700 Troost 64131
Barnard, John L., Jr., 4320 Wornall Rd. 64111
Barnett, Gordon P., 6568 High Dr., Shawnee Mission, Kan. 66208
Barr, Glenn A., 601 E. 63rd St. 64110
Barry, Gerald W., 1948 E. Parvin Rd. 64116
Barry, William B., 4320 Wornall Rd. 64111
Basantz, Fernando V., Hickman Mills Clinic, Inc., 11201 Colorado, 64137
Baska, Richard E., 24th & Gillham Rd. 64108
Bass, Lewis N., 2310 Linwood 64109
Bass, Walter R., 9503 E. 63rd St. 64133
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Baum, Frank E., 6724 Troost 64131

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Beatty, Arch J., 1816 E. 63rd 64130
Beatty, Eugene C., 24th & Gillham Rd. 64108
Beatty, Nina D., 24th & Gillham Rd. 64108
Beck, Calvin E., 4320 Wornall Rd. 64111
Becker, Richard R., 415 E. 63rd St. 64110
Becker, Rolfe A., 601 E. 63rd St. 64110
Beckloff, Gerald L., 10236 Bunker Ridge Rd. 64137
Behrends, Steven H., 24th & Cherry 64108
Bell, Hubert H., 4320 Wornall Rd. 64111
Bell, William F., 615 W. 3rd St., Lee's Summit 64063
Bennett, James D., 6700 Troost 64131
Benoit, Hector W., Jr., 4620 Nichols Parkway 64112
Benson, William F., 4320 Wornall Rd. 64111
Berenson, Sheldon E., 4620 Nichols Parkway 64112
Bergmann, Victor H., 105 Ward Parkway 64112
Berlin, Roger, 751 E. 63rd 64110
Bernreiter Michael, 1246 W. 63rd St. 64113
Berry, Maxwell G., 4320 Wornall Rd. 64111
Bickley, James E., 4620 Nichols Pkwy. 64112
Bidwell, Robert E. G., 4320 Wornall Rd. 64111
Biggs, Alfred D., 6400 Prospect Ave. 64132
Biggs, Harry L., 63rd & Evanston 64133
Bikales, Victor W., 751 E. 63rd St. 64110
Bills, Marvin L., Plaza Time Bldg. 64112
Black, Don A., 6400 Prospect Ave. 64132
Black, Eugene C., Professional Bldg. 64106
Black, Thomas C., Jr., 601 E. 63rd 64110
Blim, Richard D., 4320 Wornall Rd. 64111
Bordy, Marvin D., 601 E. 63rd St. 64110
Borenstine, Joseph, 601 E. 63rd St. 64110
Borsuk, Gregory M., 535 Blue Ridge Tower 64133
Bortnick, Eugene, 6724 Troost Ave. 64131
Botwin, Arnold E., 751 E. 63rd 64110
Boutros, Amin, P.O. Box 9309, 12011 E. 67th 64133
Bowser, John F., 4320 Wornall Rd. 64111
Boyd, George K., 5111 Independence Ave. 64124
Boyer, Philip A., Jr., 10246 Cedarbrook Ln. 64131
Boylan, Peter C., 6306 Morningside Dr. 64113
Braby, Howard H., Suite 306, 1515 W. Truman Rd., Independence 64050
Bradford, John F., 4320 Wornall Rd. 64111
Brady, Arthur M., 3039 Brooklyn 64109
Brams, Jack B., 601 E. 63rd St. 64110
Braverman, Abe E., 8300 Troost 64131
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Brumm, Lawrence W., 6400 Prospect 64132
Bruner, Robert E., 14909 Little Blue Rd. 64136
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Bryan, William H., Jr., 3939 Prospect Ave. 64130
Bryant, T. J., 751 E. 63rd 64110
Buchanan, Barbara N., 6301 Rockhill 64131
Buckingham, William W., 310 W. 49th 64112
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Budke, Harold A., 306 E. 12th St. 64106
Buhler, Victor B., 2510 East Linwood Blvd. 64128
Buie, Bruce R., 11201 Colorado 64137
Bunting, Williston P., 305 W. 43rd St. 64111
Burry, Virgil F., 24th & Gillham Rd. 64108
Butcher, Robert W., 7924 Paseo 64131
Butterworth, Nelson S., 725 W. 49th Terr. 64112
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Caldwell, John K., 6700 Troost 64131
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Heryer, John W., Wornall Rd. at 44th 64111
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° Doctor of Osteopathy.

Constitution and Bylaws

of the

Missouri State Medical Association

Adopted 1903

1974 Revision

113 MADISON JEFFERSON CITY, MO. 65101

Constitution

ARTICLE I. NAME OF THE ASSOCIATION

The name and title of this organization shall be the Missouri State Medical Association.

ARTICLE II. PURPOSE

The purpose of this Association is the promotion of the science and art of medicine, the protection of public health, the betterment of the medical profession, and, by uniting with similar organizations in other states and territories of the United States, to form the American Medical Association.

ARTICLE III. MEMBERSHIP

Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association.

ARTICLE IV. HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker, who will serve as Delegates-at-Large. It shall elect a Speaker and Vice-Speaker from its body. Its Secretary shall be the Secretary of the Missouri State Medical Association.

Included also in the House of Delegates shall be two student delegates, each from a different class, elected by the student body of each of the medical schools in the State of Missouri, who shall have the same rights and privileges as other delegates.

ARTICLE V. COUNCIL

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall be the judicial body of the Association when matters are referred to it for decision by the Association, by component societies or by individual members thereof. It shall consist of the President, President-Elect, Immediate Past-President, Secretary, Treasurer and the duly elected Councilors from each Councilor District. Nine members shall constitute a quorum.

ARTICLE VI. SESSIONS AND MEETINGS

Section 1. The Association shall hold an Annual Session at a place fixed by the House of Delegates, the time of which shall be fixed by the Council.

Sec. 2. Special meetings of the Association or of the House of Delegates may be called by a two thirds vote of the Council and shall be called upon a petition signed by members equal in number to one third of the total number of delegates certified for the last Annual Session.

ARTICLE VII. OFFICERS

Section 1. The officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and a Vice-Speaker of the House of Delegates and ten Councilors selected as provided for.

Sec. 2. All officers except Councilors shall be elected annually. The terms of Councilors shall be two years. Half of the membership of the Council shall be elected each year. The Secretary and the Treasurer shall be elected by the Council. The delegates present from each Councilor District shall meet prior to the last day of the Annual Session and elect the Councilor from that district. In the event of death, resignation or removal of any Councilor, the Council may appoint a successor to serve until the vacancy is filled at the next Annual Session. All of the officers shall serve until their successors are elected and installed.

ARTICLE VIII. FUNDS, EXPENSES AND BUDGET

Funds shall be raised by a per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates. The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

ARTICLE IX. REFERENDUM

At any General Meeting of the Association it may, by a two thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Association for its vote. A majority vote of all members of the Association shall determine the question.

Petitions signed by 10% of the active members of the Association, including petitioners representing at least one half of the component Medical Societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

ARTICLE X. SEAL

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XI. AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present and voting at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session and that it shall have been published twice during the year in the Journal of this Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

Bylaws

CHAPTER I. MEMBERSHIP

Section 1. Members of this Association shall be physicians whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine.

Sec. 2. No person who is under sentence of suspension or expulsion from any component society of this Association or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association.

Sec. 3. There shall be three classes of members as follow:

Active Members shall be limited to those members of component societies who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) if permitted by the bylaws of the component society, members who hold the degree of Doctor of Osteopathy, and (3) are entitled to exercise the rights of active membership in their component societies, as determined by their component societies, subject to the provisions of these Bylaws.

Junior members shall be limited to those members of component societies who are serving a full-time training internship or residency in a hospital approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Honor members shall be limited to Honor members of component societies, which societies have requested that active members who have reached advanced years and have long served the Association and the profession be made Honor members of the Association. They shall enjoy all the privileges of active membership and shall be exempt from the payment of dues.

Sec. 4. **Associate members** shall be limited to persons not provided for in the various classes of membership who are engaged in the pursuit of a medical or allied science, and by action of the component societies, become Associate members of the Association. Associate members shall have the right to attend scientific sessions and such other privileges as may be extended to them by the House of Delegates. They shall not be eligible to vote and shall be exempt from the payment of dues.

CHAPTER II. GENERAL MEETINGS

Section 1. The General Meetings shall be open to all registered members and guests.

Sec. 2. Any paper read before this Association shall be considered for publication in the Journal if the Author so desires. Such papers may be given publication priority over regularly submitted papers but shall be subject to the same editorial review and selection policies.

Sec. 3. No person in the active practice of medicine in the State of Missouri shall appear on the program of the Association unless he or she is a member of the Missouri State Medical Association or an affiliated association or organization.

CHAPTER III. HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Session. It shall remain in continuous session on the first day of the Annual Session and complete the work coming before it at that session.

All resolutions to be considered by the House of Delegates must be received at the Association office 45 days prior to the opening session of the House for publication in the handbook. Any resolution to be introduced after that time must be made available to the House of Delegates 24 hours before the session in which it is to be introduced. At least 200 copies of the resolution or funding for same must be supplied by the individual or society introducing the resolution.

At the second session of the House of Delegates, the same procedure would be followed, but such introduction would be allowed only if approved by two thirds of the delegates voting. It (The House of Delegates) shall meet on the last day of the annual session to receive the report of the Nominating Committee and complete unfinished business and the election of officers. The same procedure with regard to resolutions would be followed at that session, but it would then take a unanimous vote of the House to allow such introduction. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishes, condolences, congratulations and others of a personal nature.

Sec. 2. Each component county society shall be entitled to send each year one delegate or one alternate to the House of Delegates for each fifty full paid members or fraction thereof in the Association on December 31 of the previous year, plus one additional delegate or alternate for each one hundred members or a major fraction thereof; provided, however, that each component society which is composed of two or more county societies shall be entitled to at least one delegate from each of the counties of which it is composed; and provided that when two or more counties hereafter combine into a hyphenated society, such society shall not lose any delegates by reason thereof; however, such delegates must reside or practice in the county they represent. Alternate delegates may be elected from the entire membership of the component medical societies. All Past-Presidents of the Association, the Speaker and Vice-Speaker shall serve as Delegates-at-Large.

Sec. 2A. Each of the medical schools in the State of Missouri shall be entitled to send each year two student delegates, each from a different class, elected by the student body of the said medical school. The names of such student delegates shall be certified by the Dean of said medical school to the Secretary of this Association thirty days before the Annual Session. Such student delegates shall have all the rights and privileges of all other delegates.

Sec. 3. Forty delegates shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Association.

Sec. 4. From among members of the House of Delegates the Speaker shall appoint reference committees to which reports and resolutions, on a majority vote of the House of Delegates, shall be referred as follows:

Reference Committee on Amendments to the Constitution and Bylaws.

Reference Committee on Resolutions.

Reference Committee on Miscellaneous Affairs.

Reference Committee on Medical Education and Public Welfare.

Reference Committee on Reports of Officers.

The Speaker may appoint such other reference committees as he may deem necessary, upon approval of the House of Delegates.

The President shall appoint a Committee on Credentials.

Sec. 5. The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Sec. 6. The House of Delegates shall divide the state into Councilor Districts specifying what counties each district shall include and, when the best interest of the Association and the profession will be promoted thereby, organize in each a district medical society of which all members of the component county societies shall be members.

Sec. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Sec. 8. The House of Delegates shall receive and act upon a complete and detailed annual audit of receipts and expenses of the preceding year and a proposed budget for the current calendar year which shall have been prepared by the Council and submitted to the component county societies at least four weeks prior to the Annual Session. These shall be published in the Journal.

Sec. 9. The following shall be the general order of business of the House of Delegates for the first meeting of the session:

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll call.
4. Reading and adoption of minutes.
5. Report of officers.
6. Report of committees.
7. Unfinished business.
8. New business.

The following shall be the general order of business of the House of Delegates for the last meeting of the session:

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll call.
4. Reading and adoption of minutes.
5. Report of the Nominating Committee.
6. Election of officers.
7. Reports of officers.
8. Reports of committees.
9. Unfinished business.
10. New business (see Sec. 1, Chap. III).
11. Installation of officers.
12. President's appointments and installation of members to committees.
13. Selection of the place for the next Annual Session.

At any meeting of the House of Delegates, the order of business may be changed by a two thirds affirmative vote of the members present and voting.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President on the first day of the Annual Session shall select a Committee on Nominations consisting of ten delegates, no two of whom shall be from the same Councilor District. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the name of one member for each of the offices listed in Article VII of the Constitution which are to be filled at that Annual Session excepting the President-Elect who shall be nominated from the floor of the House of Delegates.

Sec. 2. All elections of officers shall be by acclamation unless ballot is called for. A majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association, who shall be elected as follows:

In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the votes, the nominees shall be declared elected in the order of the highest number of votes received until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

In case no nominee for general offices of the Association (see Article VII, Constitution) receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected.

Sec. 3. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Sec. 4. Delegates present at the Annual Session from Councilor Districts whose Councilors' terms expire shall hold meetings on or before the morning of the last day of the Annual Session and elect a Councilor for their District for a term of two years. The name of the elected Councilor shall be given on a prescribed form to the Secretary for presentation to the House of Delegates. Each candidate for Councilor must reside or practice in the district for which he is elected.

Sec. 5. The Speaker and Vice-Speaker shall not serve more than three consecutive terms.

Sec. 6. The Speaker shall appoint a parliamentarian to serve as such during the session of the House of Delegates at each Annual Session and upon whom the Speaker may call before deciding points of order or procedure.

CHAPTER V. DUTIES OF OFFICERS

Section 1. The **President**, or his designated representative, shall preside at all scientific sessions of the Association. He shall preside at the House of Delegates in the absence of the Speaker or Vice-Speaker and until their successors are elected. He shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such other duties as custom or parliamentary usage requires. He shall be the real head of the profession of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2. The **President** and the **President-Elect** shall be members of the Council and shall attend all meetings of the Council. Should the office of President-Elect become vacant through death or otherwise the Council may fill the vacancy until the next Annual Session of the Association.

Sec. 3. The **Vice-Presidents** shall assist the President in the discharge of his duties. In the event of the death, resignation or removal of the President the Council shall select one of the Vice-Presidents to serve the unexpired term.

Sec. 4. The **Treasurer** shall give bond in the sum of $20,000. He shall demand and receive all funds due the Association, together with bequests and donations. He shall pay money out of the treasury only on a written order of the President, countersigned by the Secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his actions and of the state of the funds in his hands.

Sec. 5. The **Secretary** shall attend the General Meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and shall keep a record of its proceedings. He shall be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the Annual Session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its Secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their reports and shall collect from them the regular per capita dues and assessments and turn the same over to the Treasurer. The amount of his salary shall be fixed by the Council.

Chapter VI. Council

Section 1. The Council shall meet during the Annual Session at such times as necessity may require, subject to the call of the Chairman or on petition of three Councilors. It shall meet on the last day of the Annual Session to organize. The Council shall elect a Chairman and a Vice-Chairman for a term of one year. The Chairman may be reelected to serve not more than four consecutive terms of one year each. The Council shall, through its Chairman, make an annual report to the House of Delegates.

Sec. 2. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exists, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. He shall make reports of his work and the condition of the profession of each county in his district to the Council. The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed on a proper itemized statement submitted monthly and within the current year, but this shall not include his expense in attending the Annual Session of the Association. No Councilor shall be eligible for the position of Delegate to the House of Delegates during his term of office as Councilor, nor shall he vote in the House of Delegates.

Sec. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec. 4. The District Councilor together with two members of component societies within the Council District, selected by the Councilor, shall serve as a Board to hear and by a majority vote adjudicate any questions involving the right and standing of members, either in relation to other members or to component societies or to the Association, and all matters of discipline affecting the conduct of members of component societies, or other matters.

The Council shall be the appellate Board of Censors of the Association. It shall hear and adjudicate all matters on appeal from the decision of the Councilor Board; it shall hear and adjudicate matters of an ethical nature brought before the House of Delegates or the general meeting which shall be referred to the Council without discussion. On original decision or appellate determination, its decision shall be final unless appealed to the then convened meeting or the next meeting of the House of Delegates.

Sec. 5. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the President and Secretary of this Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec. 6. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 7. The Council shall provide for and supervise the issuance of all publications of the Association including proceedings, transactions and memoirs, and shall have authority to appoint an Editor and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members, to be known as a Committee on Auditing and Appropriations, shall audit all accounts of this Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association for the following calendar year. This budget shall be prepared and presented for consideration in the last quarter of each year by the Committee on Auditing and Appropriations. A complete and detailed report shall be submitted to the component county medical societies as provided in Section 8, Chapter III. The Council shall submit an annual report of the House of Delegates which shall specify the character and cost of the publications of the Association, the amount and character of all its property, and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Sec. 8. The Council shall appoint at least six months before the Annual Session, a committee consisting of three of its members to be known as the Committee on Arrangements for the Annual Session. On recommendation of the Committee, the Council shall appoint a general chairman of a Local Committee on Arrangements, who shall be a member of the component society of the county in which the Annual Session is to be held, and who shall appoint and organize from the members of this county society the personnel of the Local Committee on Arrangements. The Local Committee on Arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the Annual Session. All receipts and disbursements related to the Annual Session shall be handled by the Committee on Arrangements on recommendations of the Committee on Budget and Appropriations.

Sec. 9. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Sessions of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

Sec. 10. The salaries of all employees of the Association shall be fixed by the Council.

Sec. 11. The Council shall provide such headquarters for the Association as may be required to conduct its business properly.

Sec. 12. The Council shall be empowered to elect an Executive Secretary and Assistant Executive Secretary and such other personnel as may be necessary, who need not be members of the Missouri State Medical Association, each of whom shall perform such duties as the Council may designate and receive such salary and serve for such periods and under such conditions as the Council may determine.

CHAPTER VII. COMMITTEES AND COMMISSIONS

Section 1. Standing Committees of the Missouri State Medical Association, the chairman of which shall be appointed by the Association President unless otherwise provided in these Bylaws, will be as follows:

Executive Committee.
Committee on Constitution and Bylaws.
Committee on Publication.
Committee on Legislative Affairs.
Committee on Planning.
Committee on Voluntary Health Agencies.

The **Executive Committee** shall consist of the Association President, President-Elect, Secretary, Treasurer, Council Chairman and Council Vice-Chairman. The President of the Association shall be Chairman of the Executive Committee. The Executive Committee shall plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's Office between meetings of the Council, but shall be responsible at all times to the Council.

The Committee on **Constitution and Bylaws** shall consist of five members named by the President and shall propose such amendments to the Constitution and Bylaws as are deemed wise and expedient, and bring before the House of Delegates such amendments as it or other members of the Association may present for consideration. The President shall appoint one member for one year, two members for two years and two members for three years. As the term of each expires, his successor shall be appointed for a term of three years.

The Committee on **Publication** shall consist of five members and be appointed annually by the Council and shall be responsible for general publication and distribution policies of the Journal. The Editor of the Journal shall be designated by the Council and also shall serve as Chairman of the Committee on Publication. The Editor shall be empowered to nominate an Editorial Board, subject to approval by the Council. The members of the Editorial Board will assist the Editor in soliciting, preparing and reviewing material for publication in the Journal.

The Committee on **Legislative Affairs** shall consist of five members of the Association, appointed annually by the President. The Committee shall consider legislative proposals affecting health problems of the people of the state and the practice of medicine and shall make recommendations to the Council and the House of Delegates as well as directing staff activities in such matters.

The **Planning Committee** shall consist of ten members to be appointed by the President. Two members shall be appointed for one year, two for two years, two for three years, two for four years and two for five years. As the term of each expires, his successor shall be appointed for a term of five years. In making such appointments, the President shall be governed by experience of the member, the size of his medical society and his geographical area, so as to have a representative committee. Age of the members shall be considered to the end that one-third to one-half of the committee shall be of an age group that should contemplate ten to twenty years more of active practice.

The Committee on **Voluntary Health Agencies** shall consist of five members of the Association appointed by the President. Two members shall be appointed for three years, two members for two years and one member for one year. As the term of each expires, his successor shall be appointed for a term of three years. The Committee on Voluntary Health Agencies shall provide liaison and work with all voluntary health organizations.

Section 2. Standing Commissions of the Missouri State Medical Association, who shall be responsible to the Council and whose chaiman shall be appointed by the Association President, will be as follows:

Commission on Public Affairs.

Commission on Medical Economics, Third Party and Governmental Relations.

Commission on Continuing Education and Health Manpower.

Commission on Medical-Legal Affairs.

Commission on Interspecialty Medicine.

Subsection a. The standing Commissions, unless otherwise provided in these Bylaws, shall consist of fifteen members serving three-year terms and the terms will be staggered so that the President will appoint five members of each Commission each year. Initially, the President will appoint five members to one-year terms, five members to two-year terms and five members to three-year terms and no member shall serve more than two consecutive terms.

Subsection b. The Chairman of each Commission may appoint Ad Hoc Committees to carry out the Commission's programs. These Ad Hoc Committees may include any Missouri State Medical Association member.

Subsection c. The Chairman of the Council shall appoint each year an appropriate Councilor to serve as advisor to each respective Commission.

The Commission on **Public Affairs** shall plan and execute programs designed to enhance the relationship between the public and the medical profession. The Commission shall have responsibility in the fields of industrial health, environmental health, medicine and religion, trauma, disaster medical care and national defense and other public matters.

The Commission on **Medical Economics. Third Party Medicine and Governmental Relations** shall keep close liaison and work with peer and utilization review mechanisms, insurance intermediaries and governmental agencies.

The Commission on **Continuing Education and Health Manpower** shall determine the character and scope of the scientific proceedings of the Association for each annual session as well as to make all arrangements for such annual sessions, subject to the instructions of the House of Delegates. The Commission shall also be responsible for the entire continuing education program of the Association, shall have all matters pertaining to hospitals referred to it, shall carry on all programs in the recruitment of health manpower in professional as well as in allied health fields and shall be responsible for programs in the rural health field.

The Commission on **Medical-Legal Affairs** shall investigate and study medical-legal matters affecting the practice of medicine, make recommendations to the Council and House of Delegates and also make certain that all Association members are kept informed of important developments in this field. The Commission also may work with similar groups formed by the State Bar Association on matters of joint interest and concern as well as with governmental and insurance agencies in this field.

The Commission on **Interspecialty Medicine** shall be composed of one representative of each statewide specialty group as recognized by the Association Council. The President of the Missouri State Medical Association shall appoint annually to the Commission a representative from each of the authorized groups as submitted to him by the specialty organization. In the event that such a nominee is not submitted to him by an organization, the Association President may designate a member of that specialty group to serve on the Commission.

The Commission shall be charged with the responsibility of reviewing organization problems with respect to scientific programs, socio-economic and legislative matters that affect their particular specialties; in addition the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. Also, the Commission shall provide close liaison between the various specialty organizations and the Missouri State Medical Association.

Section 3. Fifty percent of a Committee or a Commission should be present at an official meeting to constitute a quorum.

Section 4. Special committees may be appointed by the President or the Council as circumstances may demand.

CHAPTER VIII. DUES AND ASSESSMENTS

Section 1. (a) The annual dues of this Association shall be $90.00, which shall be applicable to each active member of the Association beginning in 1975 and shall be levied per capita on the active members of the component societies; the per capita levy for junior members shall be $10.00 per year; honor and associate members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied.

(b) An assessment of $10.00 per year on each active member of the Association shall be applicable for a three-year period beginning in 1975. The assessment shall be payable with the dues of the Association, and the monies collected therefrom shall be remitted to the Missouri State Medical Foundation.

Sec. 2. Three dollars of the annual dues shall be credited to the account of the Journal for each member's annual subscription. The remainder of the amount shall be credited to the general fund of the Association.

Sec. 3. The House of Delegates may, when in its judgment the best interest of the Association demands, recommend an assessment on each active and junior member. Such assessment shall be levied only by consent of two thirds of the members of the House of Delegates present and voting. Funds obtained from such special assessments shall be allocated only for the purposes for which such assessment is levied and in accordance with substantiating budgets. Unexpended balances from such assessments must be reported to the House of Delegates for re-allocation.

Sec. 4. The secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the per capita levies. Any member whose name has not been reported for enrollment and whose dues have not been remitted to the Treasurer of this Association on or before March 1 shall stand suspended until his name is properly reported and his dues for the current year are paid. On December 31 of each year, members delinquent in payment of dues, and assessment if such has been made, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an annual session.

Chapter IX. Rules of Conduct

The ethical principles governing the members of the American Medical Association shall govern members of this Association.

Chapter X. Rules of Order

The deliberations of this Association shall be conducted in accordance with parliamentary usage as defined in *Robert's Rules of Order.*

Chapter XI. County Societies

Section 1. All county societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Association provided that their Constitutions and Bylaws shall have been submitted to the Council and received its approval.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Association. Every reputable and legally qualified physician who does not practice, nor profess to practice sectarian medicine, and who resides or practices in the same county, who shall apply for membership on the prescribed form and subscribe for the Journal and pay the annual dues and assessments for the current year, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council of the State Association shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

The Council may upon request of a component society remit the state dues and assessment of a member who has become totally and permanently incapacitated through mental or physical disability and has been a member in good standing during the three consecutive years immediately preceding his disability; provided, that the component society shall remit the county society dues of such member.

The Council may, upon request of a component society, remit the state dues and assessments of a deserving member, found to fall within what is classified as a hardship case, during the period of said hardship until such time as the dues again become payable; provided that the component society shall remit the county society dues of such member.

The Council may, upon the request of a component society, waive the dues of any member in good standing for such a period as the member is serving in the Armed Forces of the United States of America, or similar service with any of the allies of the United States, and for six months thereafter.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

Sec. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Association for final determination.

Sec. 5. In hearing appeals the Council may admit oral or written evidence or both as in its judgment will most fairly present the facts.

Sec. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he moves such member shall be considered to be in good standing in the county society from which he was certified and in the State Association to the end of the period for which his dues have been paid.

A member of a component society who moves to and engages in the practice of medicine at a location in another county in which there is a component society shall forfeit his membership in this Association and the Secretary shall remove his name from the roster of members of the Missouri State Medical Association unless within one year after such change of residence he becomes a member of the component society in the county to which he has moved.

Sec. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

Sec. 8. At some meeting in advance of the Annual Session of this Association, each component county society shall elect one or more delegates and an equal number of alternates therefor to represent it in the House of Delegates of this Association, in accordance with Chapter III, Section 2 of these Bylaws. The secretary of each county society shall send a list of such delegates and alternates to the Secretary of this Association at least sixty days before the Annual Session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Sec. 9. The secretary of each county society shall keep a roster of its members and, if practicable, a list of non-affiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by the Council. He shall send a copy of the program of each meeting to his district councilor and to the Secretary of the State Association.

Sec. 10. Any county component society, in a manner approved by the State Association, or the State Association with the consent of the county society or societies affected, may undertake, organize and put into effect plans for the medical care of indigent persons or indigent groups, and low income groups, by agreements with physicians, public officials or others and by the use of contributions, cooperative funds or other means; provided, however, that a free choice of the available and participating physicians in that territory shall be allowed to the patient and that all relationships, legal or otherwise, between the physician and the patient shall be and remain as though it were strictly an individual employment.

Chapter XII. Amendments

Section 1. These Bylaws may be amended at any Annual Session by a two-thirds vote of the delegates present and voting at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid on the table for one day.

Sec. 2. Upon the adoption of this Constitution and these Bylaws all previous constitutions and bylaws are thereby repealed.

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Lambie, Rodger W., 701 E. 63rd St. 64110
Landers, Burnell, 6724 Troost 64131
Landis, George K., Professional Bldg. 64106
Lapi, Angelo, 2012 Stratford Rd., Shawnee Mission, Kan. 66208
Lapp, Harry C., 221 West 51st 64112
Latham, Raymond W., 4620 Nichols Parkway 64112
Lauer, Daniel J., 4320 Wornall Rd. 64111
Layle, John K., Jr., 4320 Wornall Rd. 64111
Layton, Ira C., 6400 Prospect 64132
Lee, Gerald B., 101 Memorial Dr. 64108
Lee, Henry A., 6700 Troost 64131
Lee, King Ying, 6700 Troost 64131
Lee, Tae Hung, 6400 Prospect 64132
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Leitch, Cecil G., Rt. 2, Box 222, Blue Springs 64015
Lentz, Clark H., BMA Tower 64141
Leo, William A., 6400 Prospect 64132
Leonidas, John C., 24th & Gillham Rd. 64108
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McAfee, R. Gordon, 6400 Prospect 64132
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Gardner, Joseph A., 3209 McClelland Blvd. 64801
Gaston, Samuel Lee, 101 Medical Arts Bldg. 64801
Grubb, Paul H., 2509 Jackson 64803
Hall, Marvin F., Medical Arts Bldg. 64801
Hallaba, M. A. S., 25th & Jackson 64801
Hamilton, Eugene H., Medical Arts Bldg. 64801
Hilton, Paul E., 1612 Murphy Blvd. 64801
Holtzman, Samuel, 3001 M. L. King Dr., Apt. 201, Chicago, Ill. 60616
Hurst, Wilfred W., Medical Arts Bldg. 64801
Hwang, Yung H., 1515 Hazel Ave., Carthage 64836
Isbell, Charles H., Carthage 64836
Jeans, Virgil, 660 Jaccard Pl. 64801
Kirkman, Robert E., 2529 Jackson 64803
Koehler, John W., 3103 McClelland Blvd. 64801
Kuhn, John R., Jr., Frisco Bldg. 64801
Longenecker, Joe L., 2503 Jackson 64803
McGonigle, James P., 718 Illinois 64801
McKee, Howard B., 2201 Sergeant 64803
McPike, Lloyd H., 2401 Jackson 64801
MacLaughlin, James C., 3103 McClelland 64801
Manalo, Gil Baleva, Jr., 1320 S. Main, Carthage 64836
Martin, Clarence A., 2419 E. 10th 64801
Mueller, Adolph R., Jr., 2700 McClelland 64801
Paddock, Charles S., 3905 Rangeline 64801
Patterson, Donald R., 2509 Jackson 64803
Patterson, Grover S., 510 S. Main, Carthage 64836
Pence, F. Wendell, 612 S. Main, Carthage 64836
Poor, Carl W., Rt. 1, Box 302, Neosho 64850
Post, Winfred L., 2630 E. 15th 64801
Powell, Robert G., 2329 Jackson 64803
Pryor, Ira J., 2700 McClelland 64801
Roberts, Howard H., 3209 McClelland 64801
Rovce, James J., Sarcoxie 64862
Schmidt, Herbert J., 3209 McClelland 64801
Schoeberl, Cletus B., Medical Arts Bldg. 64801
Schulte, Gregorv A., 2125 Jackson 64803
Scorse, Sidney W., 619 W. 2nd 64801
Shanahan, Mary P., P.O. Box 2125 64801
Silliman, York E., 2625 Wisconsin Ave. 64801
Simmons, Jess S., Jr., 2700 McClelland 64801
Singleton, Marvin A., 114 W. 32nd 64801
Smith, Roland T., Medical Arts Bldg. 64801
Smith, W. Russell, 211 E. Chestnut, Carthage 64836
Straub, David L., 3107 McClelland 64801
Vinson, Harold A., 4242 S. Oswego, Tulsa, Okla. 74135
Walker, Paul W., Medical Arts Bldg. 64801
Whitten, M. Foster, 616 W. Centennial, Carthage 64836
Wieman, Harry K., Medical Arts Bldg. 64801
Wilcox, Ruth E., 614a Joplin St. 64801
Willcoxon, Robert L., Medical Arts Bldg. 64801
Wilson, Alice H., Rt. 1, Box 163, Neosho 64850
Wood, George H., 1515 Hazel, Carthage 64836
Wooldridge, Bart F., Medical Arts Bldg. 64801
Young, Calvin C., Jr., Medical Arts Bldg. 64801

JEFFERSON COUNTY MEDICAL SOCIETY

Albano, Benjamin I., 114 Mississippi Ave., Crystal City 63019
Allbee, Roger H., Crystal City 63019
Bai, Sangzin, 233 Main St., Festus 63028
Blank, Michael K., 5667 Castle Glade, San Antonio, Tex. 78218
Bonifacio, Andres, 121 Mississippi Ave., Crystal City 63019
Carroll, Richard C., 4700 James Dr., Metairie, La. 70003
Carron, Joseph F., 1611 Hobelman, Arnold 63010
Deles, Vicente D., Crystal City 63019
Donnell, Harold E., De Soto 63020
Donnell, Robert H., Crystal City 63019
Donnell, Thomas A., De Soto 63020
Edwards, Waldo B., 135 W. Adams Ave., Kirkwood 63122
Glasgow, David S., Crystal City 63019
Judge, Walter T., Crystal City 63019
Kang, Chang H., 105 Easton Ave., De Soto 63020
Kozal, Francis L., Crystal City 63019
Mayfield, James L., Crystal City 63019
Navato, Jose, 938 Brookvale Terr., Manchester 63011
Park, Duk Jae, 106 N. Mill St., Festus 63028
Rice, Carl E., 731 Mississippi, Crystal City 63019
Rutledge, John F., Festus 63028
Sirintrapun, Seyvee, 1588 Westvale Dr., Festus 63028
Yoskit, Harry, Festus 63028

JOHNSON COUNTY MEDICAL SOCIETY
(Warrensburg 64093)

Cooper, R. Lee, Warrensburg
Cooper, Robert S., II, 122 E. Market, Warrensburg
Damron, Oscar H., Warrensburg
Folkner, A. L.. Warrensburg
Gonzalez, M. Garza, Warrensburg
Grove, Gulph W., Knob Noster 65336
Hanna, Hugh A., Warrensburg
Harkness, Harry, 331 Hanover Arms Ct., Winston-Salem, N. C. 27104
Hobbs, George H., Warrensburg
Johnson, Charles S., Warrensburg
Jones, Keith D., Warrensburg
Lederer, Charles M., Warrensburg
Maxson, T. Reed. Warrensburg
Ragland, Jerry, Warrensburg
Reynolds, M. Wayne, P. O. Box 86, Warrensburg

KNOX COUNTY
(North Central Counties Medical Society)

LACLEDE COUNTY
(Mid-Missouri County Medical Society)

LAFAYETTE-RAY COUNTY MEDICAL SOCIETY

Baik, Kil Y., Waverly 64096
Baldwin, Theodore R., 1236 Jesse James Rd., Excelsior Springs 64024
Best, Robert, 9127 Riggs, Apt. 3, Overland Park, Kan. 66212
Boydston, Catherine, Odessa 64076
Boydston, W. Wayne, Odessa 64076
Brady, Hugh S., Concordia 64020
Brasher, Ben H., Lexington 64067
Cook, Thomas B., Richmond 64085
Cope, Joseph S., Lexington 64067
Crayton, Billy G., Waverly 64096
Crozier, Franklin A., Richmond 64085
Davault, George K., Richmond 64085
Goldberg, Isadore E., Bravmer 64624
Huber, K. Herbert, 832 Dakota Ct., Livermore, Calif. 94550
Kelling, Jordan, Waverly 64096
Koppenbrink, Walter E., Jr., 1712 Main, Higginsville 64037
LaHue, William C., 1901 Sleepy Hollow Dr., Lexington 64067
McFadden, Gene A., Waverly 64096
Meyer, Jerry L., 834 Main St., Concordia 64020
Pavlu, Robert R., Waverly 64096
Riley, Charles T., Richmond 64085
Vajaranant, Manit, Medical Clinic, Lexington 64067

° Doctor of Osteopathy.

Ward, Joe, Lexington 64067
Williams, John W., Oak Grove 64075

LAWRENCE COUNTY
(Ozarks Medical Society)

LEWIS-CLARK-SCOTLAND COUNTIES MEDICAL SOCIETY

Davis, Landis Y., Canton 63435

LINCOLN COUNTY
(St. Charles-Lincoln County Medical Society)

LINN COUNTY
(Grand River Medical Society)

LIVINGSTON COUNTY
(Grand River Medical Society)

McDONALD COUNTY
(Ozarks Medical Society)

MACON COUNTY
(Chariton-Macon-Monroe-Randolph County Medical Society)

MADISON COUNTY
(Mineral Area County Medical Society)

MARIES COUNTY
(Mid-Missouri County Medical Society)

MARION-RALLS-SHELBY COUNTY MEDICAL SOCIETY
(Hannibal 63401)

Bach, Lysle M., 4209 W. Ely Rd.
Buben, Robert W., 2910 St. Mary's Ave.
Burns, Francis R., Tower Plaza, Clinic Rd.
Burton, Dale F., P.O. Box 311
Clisham, John F., B & L Bldg.
Comer, J. Russell, 23 Pauline Dr.
Fischer, Thomas J., 2910 St. Mary's
Florendo, Federico N., Jr., 1734 Market St.
Florendo, Purificacion T., 5505 Delmar, St. Louis 63112
Foreman, Phillip B., Box 311
Greene, Harry L., 109 B Virginia
Hall, Stanley G., 9 Fair Oaks
Hamlin, Wyeth, Box 311
Hinds, R. David, 3 Paulina Dr.
Jayanandaiah, H. P., 4022 Edgewood
Kruse, Carl R., 706 S. Dickerson, Palmyra 63461
Lanning, Robert J., 115 N. 5th St.
Lichty, Charles A., Shelbina 63468
Mann, James K., 4074 Hillside Dr.
Murphy, Bernard L., 2000 Crescent Dr.
Plowman, Edward M., B & L Bldg.
Rapp, Earl L., Box 311
Roller, Merrill J., 2910 St. Mary's
Steele, James C., Jr., Box 311
Walterscheid, John H., 1209 Broadway
Well, Julius W., Palmyra 63461

MERCER COUNTY
(Grand River Medical Society)

MID-MISSOURI COUNTY MEDICAL SOCIETY
(Phelps-Crawford-Dent-Pulaski-Maries-Laclede Counties)

Andreassen, Dimil F., Rolla 65401
Bass, Billy J., Salem 65560
Baumann, Albert R., Steelville 65565
Bealer, Louis A., Lebanon 65536
Butts, James D., Rolla 65401
Carnell, B. M., Camdenton 65020
Carrington, Howard W., Lebanon 65536
*Courter, Gary M., Harwood & Chestnut, Lebanon 65536
Drake, Avery A., 4357 N. 106 Ave., Phoenix, Ariz. 85039
Draper, Bernard, 700 W. 11th, Rolla 65401
Elders, Frank A., Jr., Cuba 65453
Feind, Earl E., Rolla 65401
Froelich, R. W., Lebanon 65536
Gapasin, Ernesto, Lebanon 65536
Garrison, T. W., C.P.O. Box 1042, Korea Campus Crusade for Christ, Seoul, Korea
Hammler, Christiana V., St. James 65559
Heilbrunn, Ilse, 1203 B Forum Dr., Rolla 65401
Hite, Dennis E., Lebanon 65536
Holley, Donald B., Camdenton 65020
Miller, Clyde S., Waynesville 65583
Mitchell, Roy E., Salem 65560
Myers, James M., Rolla 65401
Pendell, Paul W., 215 W. Highway 72, Rolla 65401
Riffel, Gordon W., Bourbon 65441
Russell, Barbara E., Rolla 65401
Smith, Ted P., S&S Acres, Rt. 2, Rolla 65401
Stricker, Emil A., St. James 65559
Theobald, Sterling, Box 368, Camdenton 65020
White, Eugene F., 700 W. 11th, Rolla 65401
Young, Robert B., Rolla 65401

MILLER COUNTY MEDICAL SOCIETY

Buehler, Carl T., Jr., Eldon 65026
Shelton, Edward O., Eldon 65026

MINERAL AREA COUNTY MEDICAL SOCIETY
(St. Francois-Iron-Madison-Washington-Reynolds-Bollinger Counties)

Appleberry, Charles H., Rivermines 63668
Arat, Metin, Farmington 63640
Borromeo, Carlos J., 43 St. Joe St., Rivermines 63668
Burcham, Tom R., Jr., Farmington 63640
Cancelada, Juan, Farmington 63640
Carleton, Charles E., Jr., Farmington 63640
Chastain, Charles W., Farmington 63640
Crouch, F. Richard, Farmington 63640
Datta, N. K., Bonne Terre 63628
Dennis, W. Paul, Flat River 63601
Dent, George W., Jr., 301 W. Liberty, Farmington 63640
Dettmer, Robert F., Ironton 63650
Dierker, H. D., 301 W. Liberty, Farmington 63640
Farmer, Norma D., Farmington 63640
Ford, William, Farmington 63640
Grossman, Marvin, Fredericktown 63645
Hardy, Stanton L., Desloge 63601
Harland, Robert E., 2500 Torrey Pines Rd., La Jolla, Calif. 92037
Hoctor, Emmett F., Farmington 63640
Hoye, Robert C., 301 W. Liberty, Farmington 63640
Huckstep, Robert A., Farmington 63640
Hunt, John W., Jr., Swinks Trailer Ct., Rt. 4, Farmington 63640
Karraker, Alvan G., Medical Arts Clinic, Farmington 63640
Mardini, Edward E., Bonne Terre 63628
Menne, Marvin C., Ironton 63650
Mullen, Jack, Bonne Terre 63628
Neukom, George B., Farmington State Hospital #4, Box #6, Farmington 63640
Newcomb, Arthur D., Medical Arts Bldg., Joplin 64801
Oliver, George A., Farmington 63640
Pichardo, Javier A., Farmington 63640
Rao, A. R., 703 W. Main, Fredericktown 63645
Taylor, Van W., Bonne Terre 63628
Tuttle, Jay F., Farmington State Hospital, Farmington 63640
Watkins, George L., Jr., 1105 Rancho Rd., La Jolla, Calif. 92037

MISSISSIPPI COUNTY
(SEMO County Medical Society)

MONITEAU COUNTY MEDICAL SOCIETY
(California 65018)

Fulks, Richard B., California
Gallagher, Lionel M., California
Latham, Kenyon S., California

MONROE COUNTY
(Chariton-Macon-Monroe-Randolph County Medical Society)

MONTGOMERY COUNTY MEDICAL SOCIETY

Byland, Samuel J., Wellsville 63384

MORGAN COUNTY MEDICAL SOCIETY
(Versailles 65084)

Gunn, Jack, Versailles
Hall, C. Robert, Versailles
Kauffman, Ruth, Versailles
Lyle, Robert R., Versailles
Washburn, J. Loren, Versailles

NEW MADRID COUNTY
(SEMO County Medical Society)

NEWTON COUNTY
(Ozarks Medical Society)

NORTH CENTRAL COUNTIES MEDICAL SOCIETY
(Adair-Schuyler-Knox-Sullivan-Putnam Counties)
(Kirksville 63501)

English, Milton T., Jr., Kirksville
Freeman, Spencer L., Kirksville
Grim, Edward M., 3105 McClelland Blvd., Joplin 64801
Stickler, Ralph O., 711 E. Illinois, Kirksville
Tarvydas, Francis, Edina 63537

NORTHWEST MISSOURI MEDICAL SOCIETY
(Nodaway-Holt-Atchison-Gentry-Worth Counties)

Bare, Edward F., Tarkio 64491
Bauman, Henry C., Maryville 64468
Byland, Benjamin F., Maryville 64468
Carlin, Albert L., Stanberry 64489
Carpenter, Wallace, Rock Port 64482
Dunshee, Robert E., Maryville 64468
Humphrey, James, Mound City 64470
Imes, Elvin D., Maryville 64468
Jackson, William R., Maryville 64468
Matteson, Frank B., Grant City 64456
Morgan, Troy O., Jr., Albany 64402
Niedermeyer, Edward L., Tarkio 64491
Wanamaker, John M., Rock Port 64482
Wempe, G. Raymond, Maryville 64468

OREGON COUNTY
(South Central Counties Medical Society)

OSAGE COUNTY
(Unorganized)

OZARK COUNTY
(South Central Counties Medical Society)

OZARKS MEDICAL SOCIETY
(Barry-Lawrence-Stone-Christian-Taney-Newton-McDonald Counties)

Anderson, Paul B., Neosho 64850
Apostol, Andres G., 801 Lincoln St., Monett 65708
Betz, Richard J., Neosho 64850
Betz, Robert F., Neosho 64850
Blankenship, George W., Neosho 64850
Bowman, Melvin C., Neosho 64850
Brown, Frederick B., Aurora 65605
Capetti, Alex P., Crane 65633
Carter, James R., Neosho 64850
Christianson, Charles S., Mt. Vernon 65712
Coffman, Esther E. L., P.O. Box 591, Lakeworth, Fla. 33460
Crain, James W., Branson 65616
Cruz, Sergio G., Jr., 801 Lincoln, Monett 65708
Dabbs, Wilbur D., Neosho 64850
Donley, Robert R., Monett 65708
Esparrago, Francisco R., Jr., Monett 65708
Galinsky, Leon, 128 Ritter, Republic 65738
Gardner, Joseph W., 8 Walnut Lane, Kimberling City 65686
Gillispie, Roy, Branson 65616
Glass, William J., Jr., Monett 65708
Glover, Kenneth, Mt. Vernon 65712
Graves, Arthur J., Mt. Vernon 65712
Hamilton, William P., Aurora 65605
Hellweg, Charles E., Mt. Vernon 65712
Huntington, Ione, Mt. Vernon 65712
Kelsey, Kenneth L., Aurora 65605
Kenney, Roy E., Neosho 64850
Kerr, Frank T., Monett 65708
Lentz, Harold C., Neosho 64850
Magness, William C., Branson 65616
Mars, Hartley F., Forsyth 65653
Merideth, Mary Jane, Cassville 65625
Montellano, Arturo H., 808 Euclid, Monett 65708
Morrison, T. A., Aurora 65605
Oceeno, Victor G., 808 Euclid, Monett 65708
Olive, George C., Neosho 64850
Roper, Stanley D., Ozark 65721
Shumate, L. St. Clair, Reeds Spring 65737
Spears, Charles A., 1153 W. Hwy. 76, Branson 65616
Taylor, Leo T., Neosho 64850
Wommack, Fred L., Crane 65633

PEMISCOT COUNTY MEDICAL SOCIETY

Aquino, Philip J., Caruthersville 63830
Bernard, J. W., Caruthersville 63830
Cain, Charles F., Caruthersville 63830
Cook, Oliver W., Caruthersville 63830
Grable, James, Portageville 63873
Gubin, Alan S., Caruthersville 63830
McCoy, Warren R., Caruthersville 63830
McKaskle, Clarence W., Caruthersville 63830
Painter, Andrew E., Portageville 63873
Painter, Lattie B., Jr., Portageville 63873
Shirey, Arnold G., Hayti 63851

PERRY-STE. GENEVIEVE COUNTIES MEDICAL SOCIETY

Carron, Oscar A., Perryville 63775
Craig, Ronald D., Rt. 8, Highland Acres, Lincoln, Neb. 68506
DeGenova, Gerard H., Ste. Genevieve 63670
Eugenio, Romeo R., Perry Plaza Medical Center, Perryville 63775
Fairchild, James F., Perryville 63775
Feltz, Lawrence W., Perryville 63775
Fischer, Theodore, Altenburg 63732
Key, Martin L., Center Dr. & Hospital La., Ste. Genevieve 63670
Lanning, Richard C., Ste. Genevieve 63670
Lutkewitte, Joseph F., Ste. Genevieve 63670
McDermott, Alfred E., Perryville 63775
Pontillas, Job B., Perryville 63775
Utterman, William F., Lake Forest Estates, Ste. Genevieve 63670

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*Doctor of Osteopathy.

PETTIS COUNTY MEDICAL SOCIETY
(Sedalia 65301)

Block, J. E., Rt. 2, Box 53B
Boger, James W., 500 W. 16th St.
Braverman, Elliot M., 1501 S. Grand Ave.
Brazos, John C., Smithton 65350
Campbell, Albert J., Jr., 625 E. 13th
Cole, William R., Rt. #1, Smithton 65350
Daum, Harold F., Bothwell Memorial Hosp.
Edmonds, Robert W., 1718 S. Ingram
Edwards, David R., 700 S. Limit
Eldenburg, Donald, 700 S. Limit
Elhassani, Sami B., 1805 E. 16th
Erickson, H. John, 1501 S. Grand
Fisher, Stanley D., 500 W. 16th
Glass, Robert L., 403 W. Broadway, Columbia 65201
Hopkins, Thomas J., 700 S. Limit
Hopkins, T. Spencer, 1718 S. Ingram
Lamy, John E., 400½ Dal-Whi-Mo
Lowe, Alvin L., 621 W. 16th St.
Maddox, Albert R., 116 W. Main
Owens, John H., Bothwell Memorial Hosp.
Proctor, Donald C., 700 S. Limit
Roberts, Paul A., Sweet Springs 65351
Stauffacher, C. Gordon, 700 S. Limit
Stewart, Robert H., Bothwell Memorial Hosp.
Stockwood, Robert C., 1718 S. Ingram
Van Dyke, Elmer H., 1718 S. Ingram
Walter, Archie L., 500 W. 16th St.
Worley, Charles A., Sweet Springs 65351

PHELPS COUNTY
(Mid-Missouri County Medical Society)

PIKE COUNTY MEDICAL SOCIETY

Jackson, Edward K., Clarksville 63336
Lewellen, Charles H., Louisiana 63353
Martin, W. Joe, Louisiana 63353
Middleton, John W., Louisiana 63353
Miles, Glenn E., Louisiana 63353
Nickels, Mathew L., 420 Forest Hills Dr., Louisiana 63353
Stuerman, Lawrence G., 211 S. 3rd., Louisiana 63353
Wilcoxen, William B., Bowling Green 63334

PLATTE COUNTY MEDICAL SOCIETY

Allen, S. Lloyd, 3809 N.W. 62 Terr., Kansas City 64151
Kimball, Ireland W., 5621 Valley Rd., Kansas City 64151
Thurman, Hill C., Parkville 64152
Vescovo, Paul C., 4106 Vivion Rd., Kansas City 64119
Wolfram, Philip H., 620 Commercial, Smithville 64089

POLK COUNTY
(Dallas-Hickory-Polk-Dade County Medical Society)

PULASKI COUNTY
(Mid-Missouri County Medical Society)

PUTNAM COUNTY
(North Central Counties Medical Society)

RALLS COUNTY
(Marion-Ralls-Shelby County Medical Society)

RANDOLPH COUNTY
(Chariton-Macon-Monroe-Randolph County Medical Society)

RAY COUNTY
(Lafayette-Ray County Medical Society)

REYNOLDS COUNTY
(Mineral Area County Medical Society)

RIPLEY COUNTY
(Butler-Wayne-Ripley County Medical Society)

ST. CHARLES-LINCOLN COUNTY MEDICAL SOCIETY
(St. Charles 63301)

Alisuag, Andres, Jr., 2850 W. Clay
Altman, Marvin P., 2850 W. Clay
Baird, Keim L., 2850 W. Clay St.
Bautista, Rogelio L., 324 Circle Dr., Moberly 65270
Cabrera, Tomas V., 79 Cottleville, O'Fallon 63366
Canty, Eugene J., 114 N. Main
Carpenter, James L., 2 Westbury Square
Clever, Henry W., Jr., 1301 Boonslick Rd.
Commerford, John F., 1301 Boonslick Rd.
Connelly, Michael W., #18 Huntleigh Downs, Frontenac 63131
Creech, Joseph C., Troy 63379
Crider, Russell J., 222 S. 2nd St.
Curry, Michael J., 2850 W. Clay
Damron, Edward O., Elsberry 63343
Del Pizzo, Ferdinand, Jr., 1301 Boonslick Rd.
Duling, Gerald J., 2850 W. Clay St.
Dumonceaux, Leonard J., 1360 S. 15th
DuMontier, R. J., O'Fallon 63366
Duncan, David, 2850 W. Clay
Felder, James P., 515 Jefferson
Fleming, Robert J., 100 First Capitol Dr.
Goldkamp, John D., 2850 W. Clay St.
Gore, Glenn L., 1650 Boonslick
Grim, George B., Hyws 47 & Old 40, Bil-Mac Plaza, Warrenton 63383
Hammes, Roman E., 2850 W. Clay St.
Hammond, D. Wade, 1301 Boonslick
Hanna, Fayez, 5400 Arsenal, St. Louis 63139
Hetlage, Louis P., Troy 63379
Kamada, Tsutomu, 115 W. Pitman, O'Fallon 63366
Keefe, David M., 2850 W. Clay
Keller, Robert, 704 W. Pearce Blvd., Wentzville 63385
Kingsbury, Robert J., 222 South 2nd
Kister, George E., 302 S. 2nd St.
Lincoln, James, Highway 47 E., Troy 63379
Linsenmeyer, Charles M., 117 First Capitol Dr.
McQueen, Samuel, 11636 Administration Dr., St. Louis 63141
Miller, Richard B., 2850 W. Clay
Muenster. Vincent P., 2850 W. Clay St.
Muhm, Harvard Yale, 1301 Boonslick
Neubeiser. Ben L., 2nd & Clay Sts.
Obando, Francisco J., Troy 63379
Olson, Richard O., Jr., 2850 W. Clay
Ordoukhanian, Tatool, 1301 Boonslick
Perez, Romulo G., 415 E. Cherry, Troy 63379
Perna, Vincent P., 11636 Administration Dr., Creve Coeur 63141
Poggemeier, William H., Jr., 304 S. 2nd St.
Rahman, Mohammad H., 2850 W. Clay
Reisa, Ronald C., 2850 W. Clay
Rice, Ronald B., 1301 Boonslick
Roach, Edward A., 2850 W. Clay St.
Roter, Alexander M., #2 Westbury Dr.
Rother, Paul H., 1301 Boonslick Rd.
Roxas, Generoso P., #2 Westbury
Schneider, Thomas A., 2850 W. Clay St.
Schuetz, Alfred, 904 Indian Hills
Smoller, Martin B., 2850 W. Clay St.
Soucy, John C., 2850 W. Clay
Tassi, Albert A., 601 Indian Hills
Tejero, Jonas S., 515 Jefferson
Thiele, O. K., #2 Westbury
Towers, Orville W., 1301 Boonslick Rd.
Vafi, Houshang, 1360 S. 5th
Vart, Gary R., 1650 Boonslick
Villanueva, Cesar, 3900 Rainbow Blvd., Kansas University Medical Center, Kansas City, Kan. 66103
Westerfeld, Roy A., 1301 Boonslick Rd.
Wipfler, Earl J., Jr., 405 Duckett
Yaeger, Gerald A., 2444 W. Clay St.

ST. CLAIR COUNTY
(West Central Missouri Medical Society)

ST. FRANCOIS COUNTY
(Mineral Area County Medical Society)

STE. GENEVIEVE COUNTY
(Perry-Ste. Genevieve Counties Medical Society)

ST. LOUIS MEDICAL SOCIETY
(St. Louis)

Abel, Charles C., 4511 Forest Park Blvd. 63108
Abel, Oliver, III, 4511 Forest Park Blvd. 63108
Abelardo, Miguel L., 300 S. Grand 63139
Abell, Walter E., 2253 S. 39th St. 63110
Abinoja, Conrado B., 4909 Lindenwood 63109
Abrams, Morris, #319, 4625 Lindell Blvd. 63108
Abramson, Charles L., 141 N. Meramec 63105
Acker, Harry L., 150 N. Meramec 63105
Ackerman, Lauren V., 600 S. Kingshighway 63110
Adeyemi-Doro, Henry, 2601 N. Whittier 63113
Adler, Benard C., 4511 Forest Park Blvd. 63108
Agasino, Armela R., 2244 Union Rd. 63125
Agasino, Gaudencio L., 20 Hughes Ford Rd., Sullivan 63080
Agress, Harry, 8631 Delmar 63124
Aguinaldo, Jaime A., 9313 Manchester 63119
Ahadi, Abd Ul Ahad, 13029 Ambois Dr. 63141
Ahern, Archibald M., 3915 Watson Rd. 63109
Ahlering, George H., #560, 621 S. New Ballas Rd. 63141
Ahmad, Bashir, 7933 Elton 63123
Ahuja, A. L., 5400 Arsenal 63139
Aitken, Louis F., 4989 Barnes Hosp. Plaza 63110
Aker, Umit, 911 S. Brentwood 63105
Akyol, Salim, #4 Highfield Lane 63131
Alegre, Jorge M., 114 N. Taylor 63108
Aleksander, Bernardo, 1420 Grattan 63104
Alexander, France, 18 S. Kingshighway 63108
Alexander, Frazier D., 4969 Enright Ave., 63108
Allen, Henry C., Clayton Medical Bldg., 63105
Allen, Hollis N., 2821 N. Ballas Rd. 63131
Allen, Melvin A., 3555 Sunset Office Dr. 63127
Allen, Willard M., University of Maryland, Baltimore, Md. 21201
Allen, William E., Jr., 720 N. Sarah 63108
Almiron, Osias A., 6150 Oakland Ave. 63139
Alonso, Jose Mario V., Jr., 10110 Hilltop Dr. 63128
Alonso, William A., 4989 Barnes Hosp. 63110
Alonso-Yague, P., 330 Northland Medical Bldg. 63136
Altheide, J. Paul, 4605 Lindell 63108
Alvarez, Luis L., 1606 Grattan 63104
Alvis, Bennett Y., 211 N. Meramec 63105
Alvis, Edmund B., 211 N. Meramec 63105
Amado-Ledo, David E., 300 S. Grand Ave. 63103
Amin, Navinkumar, 607 N. Grand Blvd. 63103
Amjad, Mohammed T., 1211 Blairshire Dr. Manchester 63011
Anderson, Charles B., 14 Frederick 63122
Anderson, John M., 100 N. Euclid 63108
Angelillo, John C., 4 Waterways Ct., Florissant 63033
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Ansari, Ansar H., 11553 Tivali Ln. 63141
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Racadio, Severo M., 223 Orrick 63122
Rachlin, Maxwell. 211 N. Meramec 63105
Ragland, John E., 624 Kehrs Mill Rd., Ballwin 63011
Rao, Carlo, 18 Ladue Estates 63141
Redington, James C., Jr., #1 Tuscany Pk. 63105
Reese, A. Victor, 120 E. Lockwood 63119
Reiches, Aaron J., 150 N. Meramec 63105
Reinhard, Edward H., 235 Sylvester 63119
Reitman, Stanley, #8 Heartwoods Ct. 63132
Rendleman, David D., 35 North Central, Clayton 63105
Rennard, Marvin, 2821 N. Ballas 63131
Repaso, Florante A., 433 W. Springfield, Sullivan 63080
Repp, Theodore J., 9311 Duenke Dr. 63137
Reynolds, James A., 1669 Beaucoire Dr., Warson Woods 63122
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Richmond, Michael R., 1125 Graham Rd., Florissant 63031
Riggio, Salvatore N., 9901 Gravois Rd. 63123
Roberts, Harold K., 35 N. Central 63105
Roberts, John P., 3015 Barretts Station Rd. 63122
Roberts, John R., 8649 Rosalie 63144
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Robinson, Edith C., #2 Briar Oak 63132
Roblee, Melvin A., #5 Kingston Manor 63124
Roddy, Hugh John, 601 S. Brentwood 63105
Rogers, Hunter Bryan, 300 Sylvester 63119
Rogers, John A., 8124 Roxburgh, Clayton 63105
Rohlfing, Edwin H., 315 N. Forsyth 63105
Roos, Albert, 1040 Sylvan Pl. 63122
Rosenthal, Randall, 703 S. Central, Clayton 63105
Roufa, Joseph F., 4511 Forest Park Blvd. 63108
Rouse, Ernest T., 100 N. Euclid 63108
Rubenstein, Melvin, 522 N. New Ballas Rd. 63141
Rubin, Robert, 10 Adams Ave. 63135
Ruhling, Rudy, 5203 Chippewa 63109
Ryan, John J., 28 Ridgetop 63117
Saha, Sudha R., 620 Packford, Ballwin 63011
Santillano, Antonio B., 2821 N. Ballas Rd. 63131
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Schechter, Samuel E., 8000 Bonhomme Rd. 63105
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Shatz, Burton A., 10287 Clayton Rd. 63124
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Sherman, Warren G., 3535 S. Jefferson 63118
Shipp, Robert H., 14520 Tramore Dr., Apt. 1, Chesterfield 63017
Shobe, Frank O., 100 N. Euclid, Suite 310 63108
Silver, Bernd, 530 Warren 63130
Silverberg. Charles, 45 Rio Vista Dr. 63124
Simril, Wayne A., 100 N. Euclid Ave. 63108
Sisk, James C., 141 N. Meramec Ave. 63105
Skilling, David M., Jr., 5505 Delmar 63112
Skinner. John S., 31 Willow Hill Rd. 63124
Smit, Herbert M., 3720 Washington 63108
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Solomon, Felix G., 1424 Bob O Link Pl. 63144
Sommer, Ross B., 100 N. Euclid 63108
Soto, Alberto A., 2821 N. Ballas Rd. 63131
Spector, Gene W., 4511 Forest Park Blvd. 63108
Speno, Angelo A., 11815 Point Oak Dr. 63131
Spitz, Milton A., 505 N. Lake Shore Dr., Chicago, Ill. 60611
Spoeneman, Marlin C., 7205 W. Florissant 63136
Stein, Harry J., 6917 W. Florissant 63136
Steiner, Alexander J., 141 N. Meramec Ave., Clayton 63105
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Sterling, John A., 1230 Kenmore Dr. 63122
Stevens, Robert W., 9311 Duenke Dr. 63137
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Stickle, A. W., 135 W. Adams 63122
Strauchen, Gilbert W., Box 258, Rt. 1, N. Key Largo, Fla. 33037
Stuart, Wallace, 9936 Hwy. 66, 63128
Stuebner, Roland W., 1930 Indian Hill, Marco Island, Fla. 33937
Sullivan, Wm. Wallace, Rt. 1, Box 1307, Glencoe 63038
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Talaban, Raymundo D., 703 W. Main, Fredericktown 63645
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Teiber, Frederick W., 38 Fair Oaks 63124
Thiele, Belmont R., 10201 Thornwood Dr. 63124
Tomlinson, William L., 1851 Candlewick Dr. 63131
°Toon, Thomas J., 10093 W. Florissant 63136
Torin, Bernice A., 951 Old Bonhomme Rd. 63132
Treiman, Robert C., #7 Radnor Rd. 63131
Trueblood, Alva C., Jr., 325 N. Kirkwood Rd., 63122
Trunko, Leo, 1900 Telegraph Rd. 63125
Tsifutis, Argyrios, 500 Northwest Plaza, St. Ann 63074
Turner, James K., 4570 Audubon 63110
Ulett, Pearl C., 500 Susan Rd. 63129
Valach, Frank J., 2821 N. Ballas Rd. 63131
Vatterott, Paul B., 10300 St. Charles Rock Rd., St. Ann 63074
Ventus, Manuel A., 233 S. Greentrail, Chesterfield 63017
Viers, Wayne A., 135 W. Adams 63122
Vilar, Pio M., Jr., 1521 Yarmouth, Chesterfield 63017
Viraghaty, Julius Gyula, 58 Old State Rd., Glencoe 63038
Vitale, Anthony J., 7150 Natural Bridge Rd. 63121
Vitale, Nicholas S., 7150 Natural Bridge Rd. 63121
Vollmar, Clarence J., 8787 Big Bend 63119
Votaw, Robert E., 10 Warson Terr. 63124
Walker, Harvey, Jr., 35 N. Central 63105
Walker, Willard B., 35 N. Central 63105
Walter, William L., 135 W. Adams 63122
Walters, Henry W., 35 N. Central 63105
Walther, Roy A., Jr., 925 Woodsmill Rd. 63011
Ward, Robert L., 9811 W. Florissant 63116
Waxelman, Roger J., 309 Manchester Rd., Manchester 63011
Weber, Sol, 1755 S. Grand Ave. 63104
Wee, George C., 1003 Manchester, Ellisville 63011
Weinhaus, Robert S., 150 N. Meramec 63105
Weisman, Renate D., 500 Northwest Plaza, St. Ann 63074
Welner, Amos, 4940 Audubon 63105
Wenneker, Alvin S., 8112 Delmar 63130
West, Joseph W., 135 W. Adams 63122
Westrup, Ellsworth A., 8540 Big Bend 63119
Weyerich, Noel F., 270 Glen Valley Dr., Chesterfield 63017
White, Bruce I., 4910 Forest Park 63108
White, Newton B., 12758 Honeygrove Ct. 63141
Whitener, Miles C., 580 Dielman 63132
Whitener, Paul R., 3291 Carlow Place, St. Ann 63074
Wiedershine, Leonard J., 8420 Delmar 63124
Wissmath, Frank S., 35 N. Central Ave. 63105
Wittler, Harry A., 325 N. Kirkwood 63122
Wolf, David I., 15 Vouga Ln. 63131
Wolfe, Edward, 9 Clermont 63124
Wolff, Dolores P., #3 Tuscany Park 63105
Wolff, Harold D., 8420 Delmar 63124
Wolff, Ray J., 500 Northwest Plaza, St. Ann 63074
Womack, Granville J., 2313 Charlemagne, Maryland Heights 63043
Wood, James A., 141 N. Meramec 63105
Woodruff, Sharon L., 205 Elm, Washington 63090
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Wulff, George J. L., Jr., 4911 Barnes Hospital Plaza 63110
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Yalcin, Enver, 4903 Kerth Rd. 63128
Yanow, Mitchell, 777 S. New Ballas Rd. 63141
Yap, Mardonio J. R., 7521 W. Florissant Ave. 63136

°Doctor of Osteopathy

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Yazdi, A. M., 16 Hampton Village Plaza 63109
Zeigler, Joseph M., 6 Beacon Hill, Creve Coeur 63141
Zimmerman, Herbert B., Room 808, 100 N. Euclid 63108
Zwirn, Benjamin H., 493 St. Francois, Florissant 63031

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McBurney, C. A., Slater 65349
McCorkle, E. Lee, Marshall
Raynor, Richard, Marshall
Reid, James A., Marshall
Roehrs, Marvin E., Marshall
Watson, Cecil L., Lincoln State School and Hospital, Lincoln, Ill. 62656

SCHUYLER COUNTY
(North Central Counties Medical Society)

SCOTLAND COUNTY
(Lewis-Clark-Scotland County Medical Society)

SCOTT COUNTY
(SEMO County Medical Society)

SEMO COUNTY MEDICAL SOCIETY
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(Sikeston 63801)

Ahlvin, Robert C., Delta Community Hospital, Sikeston
Blanton, J. C., Sikeston
Bruce, Leo A., Sikeston
Campbell, James W., Advance 63730
Castillo, Jose L., Missouri Delta Community Hospital, Sikeston
Cejas, Leandro P., Sikeston
Colbert, Robert S., Sikeston
Comeau, Richard, Dexter 63841
Critchlow, William C., Box 1068
Davis, Wilbur L., Charleston 63834
Dunaway, Howard A., Sikeston
Du Pont, Jean-René, Sikeston
Gifford, C. G., Sikeston
Heeb, Max A., Sikeston
Hill, Ronald T., Rt. 3, Dexter 63841
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Huang, Jun-Shen, 808 E. Wakefield
Mahboubi, A. O., Box 653
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Masters, Edwin J., 310 W. Gabriel, Advance 63730
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Sargent, John P., Sikeston
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Thornton, Fred H., 1012 N. Main, Sikeston
Throgmorton, Howard B., Sikeston
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Whitaker, T. H., East Prairie 63845
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SHELBY COUNTY
(Marion-Ralls-Shelby County Medical Society)

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(Howell-Oregon-Texas-Wright-Douglas-Ozark Counties)

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Cooper, Claude W., Thayer 65574
Dreyer, William F., Houston 65483
Fowler, Marvin L., West Plains 65775
Gentry, Marvin C., Ava 65608
Hasek, James A., Mountain Grove 65711
Hasek, O. Martin, Mountain Grove 65711
Langevin, Jack, 214 S. Main, West Plains 65775
Mayuga, Laureano G., 526 Spruce, Cabool 65445
Morgan, W. Thomas, Jr., West Plains 65775
Runez, Manuel, P.O. Box 499, 526 Spruce, Cabool 65445
Smith, C. Franklin, Willow Springs 65587
Smith, Rollin H., West Plains 65775
Spears, Joe L., Cabool, 65445
Walker, Ambrose T., 414 S. 6th, Thayer 65791
Wall, Joe A., Houston 65483
Wiles, Jack N., West Plains 65775
Wood, William W., P.O. Box 648, West Plains 65775

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(SEMO County Medical Society)

STONE COUNTY
(Ozarks Medical Society)

SULLIVAN COUNTY
(North Central Counties Medical Society)

TANEY COUNTY
(Ozarks Medical Society)

TEXAS COUNTY
(South Central Counties Medical Society)

VERNON COUNTY
(West Central Missouri Medical Society)

WARREN COUNTY
(Franklin-Gasconade-Warren County Medical Society)

WASHINGTON COUNTY
(Mineral Area County Medical Society)

WAYNE COUNTY
(Butler-Wayne-Ripley County Medical Society)

WEBSTER COUNTY MEDICAL SOCIETY

Bareis, Robert J., Marshfield 65706
Macdonnell, Thomas M., Marshfield 65706

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(Bates-Cass-Cedar-St. Clair-Vernon Counties)

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Allen, William H., Nevada 64772
Barone, Paul L., Nevada 64772
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Davis, C. Braxton, Nevada 64772
Eklund, Alfred W., Pleasant Hill 64080
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Haynie, William W., Butler 64730
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Huffman, Thomas L., 200 W. Chestnut, Butler 64730
Hughes, Derek Dominic, 4104 Rollins Rd., Columbia 65201
Jones, Edward S., Southland Shopping Center, Harrisonville 64701
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Magee, Robert L., El Dorado Springs 64744
Magruder, L. M., Nevada 64772
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Mauch, E. Jane, 900 S. Adams, Nevada 64772
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Pascoe, James J., Nevada 64772
Pearse, Roy W., Jr., Nevada 64772
Pickens, E. Allen, 909 Rosedale, Fulton 65251
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Rinck, Edward C., Nevada 64772
Seevers, Ruth, Osceola 64776
Strobach, Robert L., Butler 64730
Thies, Jerome H., Osceola 64776
Torontow, John, Nevada 64772
Wheeler, Robert L., Harrisonville 64701
Wray, Rolla B., Nevada 64772

WORTH COUNTY
(Northwest Missouri Medical Society)

Remember These Dates!

The 117th

ANNUAL SESSION

of the

Missouri State Medical Association

will be held on

APRIL 17-20, 1975

Chase-Park Plaza Hotel St. Louis

Woman's Auxiliary to MSMA

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Concordia 64020

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600 Boonville Rd., Jefferson City 65101

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WASAMA
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603 Quincy, Smithville 64089

Mrs. Larry Ozenberger (Dixie)
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St. Louis 63141

Andrew McCanse, M.D.
24th & Cherry,
Kansas City 64108

CONVENTION DATES

NORTH CENTRAL REGION WORKSHOP—OCT. 18-19, 1974

Stouffer's Cincinnati Inn, Cincinnati

STATE FALL CONFERENCE—Oct. 23-24, 1974
Springfield
Co-Chairmen
Mrs. Carle Schroff (Jeanine)
2448 Broadmoor, Springfield 65804
Mrs. Don Menchetti (Joan)
Rt. 9, Box 425-A, Springfield 65804

National Fall Conference—Oct. 6-9, 1974
Drake Hotel, Chicago

MISSOURI STATE CONVENTION—April 17-20, 1975
Chase-Park Plaza Hotel, St. Louis
Co-Chairmen
Mrs. J. Otto Lottes (Dorothy)
1028 Winwood Dr., St. Louis 63124
Mrs. Thomas Thale (Janette)
351 Meadow Brook, Ballwin 63011

North Central Regional Workshop—Oct. 17-18, 1974
Hyatt House, Oak Brook, Ill.

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(Counties Listed Alphabetically)

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Mrs. William D. Mayer (Ann)
1 Ridgeley Rd., Columbia 65201

Buchanan
Mrs. Lawrence H. Pifer (Lynne)
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Cooper
Mrs. Willard Avery
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Franklin-Gasconade-Warren
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635 Skyline Dr., Brookfield 64628
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Mrs. Pat A. Barelli (June)
5609 Mission Dr., Shawnee Mission,
Kan. 66208
Jasper
Mrs. Clarence Martin, Jr. (Ann)
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Festus 63028
Johnson
Mrs. Robert Cooper, II (Jane)
801 E. Gay St., Warrensburg 64093
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Rt. 3, Walnut Hills, Sedalia 65301
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548 Riverview La., St. Charles 63301
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Mrs. Anwar Shah
9810 Log Cabin Ct., St. Louis 63124
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Mrs. Rudy Ruhling (Dolores)
6 Webster Knolls, Webster Groves 63119
Saline
Mrs. Robert Blalock (Norma)
526 E. East Wood, Marshall 65340
South Central
Mrs. A. T. Walker (Susie)
Thayer 65775

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SECOND DISTRICT: Chariton-Macon-Monroe-Randolph,* Clark-Lewis-Scotland,* Marion-Ralls-Shelby,* North Central (Adair, Knox, Putnam, Schuyler, Sullivan).*

THIRD DISTRICT: ST. LOUIS CITY.

FOURTH DISTRICT: FRANKLIN-GASCONADE-WARREN, JEFFERSON, Lincoln-St. Charles, ST. LOUIS COUNTY.

FIFTH DISTRICT: AUDRAIN, BOONE, CALLAWAY, Camden,** COLE, COOPER, Howard,* MILLER-MORGAN-MONITEAU, Montgomery,* Osage.**

SIXTH DISTRICT: Benton,* Henry,* JOHNSON, LAFAYETTE-RAY, PETTIS, SALINE, WEST CENTRAL (Bates, Cass, Cedar, St. Clair, Vernon).

SEVENTH DISTRICT: JACKSON COUNTY.

EIGHTH DISTRICT: Barton,* Dallas-Hickory-Polk-Dade,* GREENE, JASPER, Ozarks** (Barry, Christian, Lawrence, McDonald, Newton, Stone, Taney),* Webster.*

NINTH DISTRICT: Carter-Shannon,* Mid-Missouri (Crawford, Dent, Laclede, Maries, Phelps, Pulaski),* SOUTH CENTRAL (Douglas, Howell, Oregon, Ozark, Texas, Wright).

TENTH DISTRICT: Bollinger,** BUTLER-RIPLEY-WAYNE, CAPE GIRARDEAU, DUNKLIN, MINERAL AREA (Iron, Madison, Reynolds, St. Francois, Washington), Pemiscot,* Perry-Ste. Genevieve, SEMO (Mississippi, New Madrid, Scott, Stoddard).*

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* No organized Auxiliary.
** No Medical Society.

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Mrs. Willard Bartlett, Sr. (St. Louis City) 53 Westmoreland Pl., St. Louis 63108	1928-29
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Mrs. David S. Long (West Central) M. 40, Lake Lotawana, Lee's Summit 64063	1932-33
Mrs. Hudson Talbot (St. Louis City) St. Matthew Manor, 227 Brown's Lane, Louisville, Ky. 40207	1933-34
Mrs. W. H. Goodson* (Clay)	1934-35
Mrs. M. Pinson Neal* (Boone)	1935-36
Mrs. Walter C. Kirchner* (St. Louis City)	1936-37
Mrs. Charles H. Werner* (Buchanan)	1937-38
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Mrs. J. J. Drace (Cape Girardeau) 903 Bellevue, Cape Girardeau 63701	1941-42
Mrs. Frank L. Davis* (St. Louis City)	1942-43
Mrs. Robert C. Haynes (Saline) 754 Eastwood, Marshall 65340	1943-44
Mrs. J. B. McCubbin* (Callaway)	1944-45
Mrs. Harry M. Gilkey* (Jackson)	1945-46
Mrs. W. E. Koppenbrink, Sr. (Lafayette-Ray) 1303 Main, Higginsville 64037	1946-47
Mrs. W. L. Allee* (Miller-Morgan-Moniteau)	1947-48
Mrs. August A. Werner* (St. Louis City)	1948-49
Mrs. John J. O'Connell (St. Louis County) 1937 O'Connell Ave., Overland 63114	1949-50
Mrs. Gretchen Van Del McClean (Jackson) 3510 Front St., San Diego, Calif. 92103	1950-51

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* Deceased.
** National President.

Mrs. W. Carey Cheek (Greene) 1951-52
1535 E. Meadowmere, Springfield 65804

Mrs. Richard A. Sutter (St. Louis County)** 1952-53
7215 Greenway Dr., University City 63130

Mrs. C. Alex McBurney (Saline) 1953-54
927 Hurt, Slater 65349

Mrs. Wilfred E. Martin (Lafayette-Ray) ... 1954-55
403 E. 2nd, Odessa 64076

Mrs. Frank B. Leitz (Jackson) 1955-56
308 W. 116th, Kansas City 64114

Mrs. Charles T. Shepherd (St. Louis County) 1956-57
10 Covington Meadows, St. Louis 63131

Mrs. Armand D. Fries (St. Louis City) 1957-58
11 W. Geyer Lane, St. Louis 63131

Mrs. Henry C. Bauman (Nodaway-Holt-Atchison-Gentry-Worth) 1958-59
929 W. 3rd, Maryville 64468

Mrs. Stanley S. Peterson (Greene) 1959-60
721 E. Stanford, Springfield 65804

Mrs. Jordan Kelling (Lafayette-Ray) 1960-61
P. O. Box 171, Waverly 64096

Mrs. Frederick E. Wade (Jackson) 1961-62
413 W. 62nd, Kansas City 64113

Mrs. J. Martyn Schattyn (St. Louis County) 1962-63
9 Huntleigh Downs, Frontenac, St. Louis 63131

Mrs. Lawrence S. Crispell (Jasper County) . 1963-64
911 Kensington, Joplin 64801

Mrs. Delevan Calkins* (St. Louis City) 1964-

Mrs. Ralph Woods Bohnsack (Grand River) . 1964-66
635 Skyline Dr., Brookfield 64628

Mrs. Wallace R. Stacey (Jackson) 1966-67
3407 Shady Bend Dr., Independence 64052

Mrs. John M. Williams (Clay) 1967-68
616 Ridgeway Dr., Liberty 64068

Mrs. E. F. Butler (Buchanan) 1968-69
3110 Douglas, St. Joseph 64506

Mrs. James A. Reid (Saline) 1969-70
102 E. Rea, Marshall 65340

Mrs. William M. Walker (Greene) 1970-71
845 Southern Hills Blvd., Springfield 65804

Mrs. Frank J. Valach (St. Louis County) ... 1971-72
4 Nassau Circle, Creve Coeur 63141

Mrs. Keith D. Jones (Johnson) 1972-73
711 S. Holden, Warrensburg 64093

Mrs. Charles R. William (Buchanan) 1973-74
2105 Lovers Lane, St. Joseph 64505

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* Deceased.
** National President.

Roster of Woman's Auxiliary Members by Society

BOONE COUNTY
(Columbia 65201)

Allen, Mrs. Harold, 212 Brenda La.
Allen, Mrs. Joseph, 5813 St. Charles Rd.
Allen, Mrs. Robert, 4900 St. Charles Rd.
Allen, Mrs. William, 508 W. Briarwood La.
Almond, Mrs. Carl, 213 W. Blvd. South
Arnold, Mrs. Richard O., 814 Yale
Asel, Mrs. Norman, 1112 S. Glenwood
Baker, Mrs. James M., Rt. 4
Baker, Mrs. A. Sherwood, 2620 Walther Ct.
Barbee, Mrs. Charles W., 3816 Cedar Dr.
Black, Mrs. Samuel, 300 S. Glenwood
Blackwell, Mrs. Charles, 3109 W. Rollins
Bruner, Mrs. Claude, 208 Edgewood
Bumgarner, Mrs. Roger W., 707 Timberhill Rd.
Burns, Mrs. Thomas, 310 E. Brandon Rd.
Bynum, Mrs. William R., 2606 Luan Ct.
Carnahan, Mrs. Charles E., 3801 Cedar La.
Chalkley, Mrs. Judson, 614 W. Stewart Rd.
Chapman, Mrs. C. Larry, 1916 Ridgemont
Cheek, Mrs. Charles W., 2700 Malibu Ct.
Cochran, Mrs. Donald, 112 Sappington
Colwill, Mrs. Jack M., Countryshire, Rt. 5
Cooper, Mrs. Maurice, 1000 Wayne Rd.
Cope, Mrs. James, Rt. 1, Rocheport 65279
Crowley, Mrs. William J., 7-E. Lathrop
Darnell, Mrs. Thomas F. B., 2617 Walther Ct.
Denninghoff, Mrs. James C., 1906 Vassar
De Weese, Mrs. Marion, 807 Stewart Rd.
Dexter, Mrs. James D., 510 Fairview Rd.
Eggers, Mrs. C. William, 1005 Cowan Dr.
Ferneau, Mrs. James, 1040 Queen Ann Dr.
Foote, Mrs. Jerry E., Rd. 4
Frueh, Mrs. Bartley, 108 Parkhill Dr.
Fuchs, Mrs. George, Jr., 1026 Hickory Hill Dr.
Galeota, Mrs. William, 1719 Ridgemont
Gammel, Mrs. George, 1602 Stony Brook
Garrett, Mrs. Glen, 102 E. Brandon Rd.
Gaunt, Mrs. William D., 1117 S. Glenwood
Griffin, Mrs. William T., 822 Greenwood Ct.
Hall, Mrs. David G., 1031 Bourn Ave.
Hardwicke, Mrs. Henry, Ashland 65010
Harris, Mrs. Hugh S., Jr., 801 Cowan Dr.
Harris, Mrs. Robert J., 2505 E. Broadway
Harrison, Mrs. Winston, 1220 Sunset Dr.
Hart, Mrs. William, 109 Sappington Dr.
Haw, Mrs. Marvin, 1807 Jackson
Henry, Mrs. Lawrence D., 1909 Princeton
Hubbell, Mrs. Ira G., 302 McNab Dr.
Hueser, Mrs. James, 604 W. Broadway
Ide, Mrs. Carl, 600 Laurel Dr.
Jackson, Mrs. Robert L., 1103 W. Stewart Rd.
Johnson, Mrs. Richard E., 129 Lindell Dr.
Kays, Mrs. Kenneth M., 1033 Bourn
Keown, Mrs. Kenneth, 402 Westmount
Kerr, Mrs. Earl S., 1308 Fieldcrest
La Chance, Mrs. Leopold, 324 S. Collier, Centralia 65240
Ladenson, Mrs. Roland, 704 Westmount
Landhuis, Mrs. Leo R., Rt. 3
Leech, Mrs. Charles A., 815 W. Stewart Rd.
Leeper, Mrs. Sidlee W., 606 W. Stewart Rd.
Litwiller, Mrs. Raymond W., 1312 W. Broadway
Logue, Mrs. John, 912 Crestland
Lohmar, Mrs. Roland E., Rt. 5, Box 335
Marco, Mrs. Phillip J., 1015 College Park
Marienfeld, Mrs. Carl, Rt. 1, Ashland 65010
Mayer, Mrs. William D., 1 Ridgeley Rd.
McElroy, Mrs. Glenn, 3909 W. Broadway
Miller, Mrs. LeRoy, 32 Bingham Rd.
Mitchell, Mrs. Frank, 2208 Danforth Ct.
Mitchell, Mrs. Lynn D., 200 Defoe Dr.
Mosby, Mrs. Larry D., 107 E. Brandon
Orth, Mrs. O. Gerald, 2404 Beachview Dr.
Overholser, Mrs. Milton D., 110 E. Brandon Rd.
Payne, Mrs. David, 1901 Ridgemont
Payne, Mrs. John, Rt. 5, Fulton 65251
Perez-Mesa, Mrs. Carlos, 609 Stewart Rd.
Peterson, Mrs. Vernon, 203 Thistledown Dr.
Pfefer, Mrs. Leland U., 2409 Bluff Blvd.
Pingleton, Mrs. William, 113 Tracy Dr.
Politte, Mrs. Leonard, Rt. 1, Cedar Grove
Pugh, Mrs. Reginald, 206 S. Glenwood
Rall, Mrs. Kenneth L., 1121 Danforth Dr.
Ridenhour, Mrs. C. E. Gene, Rt. 1, Cedar Grove
Rodgers, Mrs. Elrie, 202 S. Glenwood
Ross, Mrs. Gilbert, Rt. 1
Russell, Mrs. Garth, 1210 W. Broadway
Scheuber, Mrs. Charles, 505 W. Boulevard S.
Senhauser, Mrs. Donald, 1801 Ridgemont
Shipley, Mrs. William A., 802 Fairview Rd., Apt. B 5
Smith, Mrs. J. Ned, Jr., 701 W. Boulevard S.
Smith, Mrs. Joe R., 222 East Parkway
Spratt, Mrs. John, Jr., 105 S. Glenwood
Spurgeon, Mrs. Milo, 404 Edgewood Ave.
Stephenson, Mrs. Hugh E., 5 Danforth Circle
Stewart, Mrs. W. B., 1401 Ridgemont
Stoy, Mrs. Robert, 811 Canterbury Dr.
Struessel, Mrs. Kenneth, 3605 Evergreen La.
Thomas, Mrs. Robert M., 2215 Danforth Ct.
Vandervoort, Mrs. Robert L., 3813 Cedar La.
Waggoner, Mrs. Charles, 712 Hilltop Dr.
Wakerlin, Mrs. George E., 3002 Bray Ave.
Washington, Mrs. Edward L., 204 W. Stewart Rd.
Watson, Mrs. Trevor F., 2319 Bluff Blvd.
Wilson, Mrs. George P., 918 Westwinds Dr.
Wilson, Mrs. John, 1117 Woodhill Rd.
Wilson, Mrs. Vernon E., 300 E. Briarwood La.
Windmiller, Mrs. M. Eugene, 210 S. Glenwood

BUCHANAN COUNTY
(St. Joseph)

Acuff, Mrs. Robert P., 3015 Miller Rd. 64506
Andres, Mrs. Edward, 2323 Northwest Ext. Blvd. 64506
Baker, Mrs. W. C., Savannah 64485
Beck, Mrs. Paul, 3216 Coronado, 64505
Beheler, Mrs. Edward M., 4609 Stonecrest Terr. 64506
Benson, Mrs. Scott, 4515 Stonecrest Terr. 64506
Berney, Mrs. Francis, 1225 N. 10th 64501
Bryant, Mrs. Sydney, 1805 N. 33rd 64506
Butler, Mrs. E. F., 3110 Douglas 64506
Callman, Mrs. George, P. O. Box 655, Fairleigh Station 64506
Chiarottino, Mrs. Joseph, 419 N. 21st 64501
Christ, Mrs. Martin, 414 Benton Dr. 64504
Cox, Mrs. John P., 4208 Miller Rd. 64505
Craig, Mrs. Owen W. D., 2408 Colony Square E. 64506
Craig, Mrs. Richard O., 4106 Miller Rd. 64505
Du Mont, Mrs. Clarence, 1905 Francis 64501
Durham, Mrs. S. L., Dearborn 64439
Fisher, Mrs. Joseph, 2903 Ashland 64506
Forgrave, Mrs. John, 2611 Cornell 64506
Forgrave, Mrs. Leon Paul, Hundley Dr. 64506
Forman, Mrs. George W., 2412 Ashland 64506
Garrison, Mrs. David L., 5101 E. Crest Ct. 64506
Grimes, Mrs. Manning, 815 N. Noyes Blvd. 64506
Gunter, Mrs. Joe S., 5710 Karrasch 64505
Hartigan, Mrs. F. X., LaVerna Heights, Savannah 64485
Hayes, Mrs. Paul W., 610 N. Noyes Blvd. 64506
Herman, Mrs. Allen, 1909 N. 32nd 64506
Howden, Mrs. T. L., 2723 Francis 64501
Ide, Mrs. Lucien, 1416 N. 25th 64506
Kieber, Mrs. R. W., 1915 N. 33rd 64506
Kline, Mrs. Edmund, 17 Stonecrest 64506
Knepper, Mrs. Paul, 2002 Ashland 64506
Kulowski, Mrs. Jacob, 5106 Stonecrest Terr. 64506
Lee, Mrs. Carleton H., 2716 Douglas 64506
Lehman, Mrs. Philip, 91 Stonecrest 64506
Maginn, Mrs. R. L., 12 Wishbone Rd. 64506
Marston, Mrs. F. James, 2114 Lovers La. 64505
Martin, Mrs. John, 9 Lindenwood La. 64505
McDaniel, Mrs. John, 1808 N. 29th 64506
McDonald, Mrs. Wilbur, 6 Country Club 64505
McGlothlan, Mrs. A. B., 821 N. 24th 64506
Moen, Mrs. Berwyn H., 2214 Carper Dr. 64506
Morse, Mrs. John Philip, 2212 Lovers La. 64505
Morse, Mrs. Marvin, 2702 Faraon 64501
Mothershead, Mrs. John L., 2630 Fairleigh Terr. 64506
Ness, Mrs. Carl, 8 Lindenwood La. 64505
O'Brien, Mrs. Liam, State Hospital, Box 263, 64502
O'Connor, Mrs. William B., 2316 N. 22nd 64505
Ozenberger, Mrs. Larry, 302 Birch Ave., Plattsburg 64477
Paulson, Mrs. Gordon, 1820 Ashland Ave. 64506
Petersen, Mrs. Harold E., 2902 Frederick 64506
Pfeffer, Mrs. Robert, 1915 N. 29th 64506
Pifer, Mrs. Lawrence, 2120 Manchester Rd. 64505
Potter, Mrs. Caryl Jr., 1 Pine Rd. 64505
Potter, Mrs. Thompson, 2106 Lovers La. 64505
Prokop, Mrs. Joseph, 29 Stonecrest 64506
Redmond, Mrs. William, 3102 Jule 64501
Riddell, Mrs. Richard V., 2610 Indian Trail Dr. 64506
Rogers, Mrs. John, 2502 Ashland 64506
Rosenthal, Mrs. Irwin, 5007 Stonecrest Terr. 64506
Rost, Mrs. William, 2221 Northwest Ext. 64506
Saferstein, Mrs. T. H., 2903 Sherman 64504
Senne, Mrs. Herbert, 1308 S. Noyes 64507
Senor, Mrs. Earl, 2920 Renick 64507
Shevlin, Mrs. Charles F., 840 N. 25th 64506
Smith, Mrs. Clifton, 2821 Ashland 64506
Stallard, Mrs. Donald, 1417 N. 25th 64506
Stevens, Mrs. Edward, 2923 Joslin La. 64506
Thompson, Mrs. F. Gregg, III, 2714 Ashland 64506
Villahermosa, Mrs. Juanito, 511 Crestview Dr., Savannah 64485
Wadlow, Mrs. Ernest E., 2611 Lovers La. 64506
Waggoner, Mrs. Sharon E., 5820 S. 3rd 64504
Weed, Mrs. Randall W., 1821 Clay 64501
Weinand, Mrs. Ernest, 2002 N. 29th 64506
Whitsell, Mrs. Ora Earl, 2306 Sacramento 64507
Willman, Mrs. Charles, 2105 Lovers La. 64505

BUTLER-WAYNE-RIPLEY COUNTIES
(Poplar Bluff 63901)

Biggs, Mrs. Fred J., Jr., 808 N. Main
Brookreson, Mrs. A. F., Rt. 6, N. Main
Caldwell, Mrs. Fred, 2008 King Rd.
Carlson, Mrs. E. C., 1260 Barron Rd.
Christy, Mrs. John, 1708 Sylvan Dr.
Engelhardt, Mrs. Robert C., 1513 Rosedale La.
Gernstetter, Mrs. S. L., P. O. Box 337
Hansbrough, Mrs. Eugene T., Lurlyn Rd.
Hecker, Mrs. Joseph E., 2019 Woodhaven
Hoja, Mrs. W. Alexander, Rt. 2, Box 16
Hunt, Mrs. John, Rt. 6
Kelley, Mrs. Kenneth H., 2036 King Rd.
Laatsch, Mrs. Robert H., 1333 Meadow La.
Ladyman, Mrs. George H., 1405 Lurlyn Rd.
Markel, Mrs. A. D., 2105 Jackson Rd.
McCauley, Mrs. B. J., Box 238, Doniphan 63935
McLane, Mrs. Jerry F., 2107 Jackson Rd.
Miller, Mrs. David V., Rt. 1
Parker, Mrs. Arthur C., Jr., 708 Selma
Ramirez, Mrs. Ricardo, 2022 King Rd.
Reddy, Mrs. A. N., 2133 Sunset
Reddy, Mrs. S. K., 2630 N. 14th
Ruff, Mrs. T. Eugene, 1411 Rosedale
Till, Mrs. Bennie, 2030 Meadows Rd.
Tinsley, Mrs. Austin R., 833 Oak Hill Dr.
Traxel, Mrs. William L., 2624 Valley Crest
Tuma, Mrs. A. T., 1601 Big Bend Rd.
Varma, Mrs. D. K., 2506 N. Main
White, Mrs. Barry B., 2521 Park Pl.
Woods, Mrs. Tom, 2008 Schweitzer Dr.

CALLAWAY COUNTY
(Fulton 65251)

Brown, Mrs. John J., 1304 N. Vine
Cremer, Mrs. William J., State Hospital Dr.
Domke, Mrs. Herbert R., Rt. 2, Box 364, New Bloomfield 65063
Durst, Mrs. Henry, 1 Ivy Lane
Garner, Mrs. Royal S., Rt. 1, Box 265B, Holts Summit 65043
Groce, Mrs. George, 1 Bartley La.
Jackson, Mrs. Vernon, State Hospital Dr.
Osbourn, Mrs. Richard, 503 Douglas Blvd.
Peterson, Mrs. Donald, State Hospital # 1
Ritterbusch, Mrs. James K., 2 Bartley La.
Sydow, Mrs. Henry, 1411 Kenwood Dr.
Wood, Mrs. George F., 1700 Plaza Dr.

CAPE GIRARDEAU COUNTY
(Cape Girardeau 63701)

Alyea, Mrs. James, 1869 Drury La.
Ashley, Mrs. Hugh V., Jr., P.O. Box 618
Bahn, Mrs. Charles, 2418 Brookwood Dr.
Barnes, Mrs. Seth, 1854 Broadway
Blankenship, Mrs. Dale, 1420 Sylvan La.
Bowman, Mrs. Kirk, 1965 Robinhood Circle
Burford, Mrs. Edwin K., 2424 Terry Hill
Campbell, Mrs. Edward, 1100 N. Henderson
Chapman, Mrs. Jean Allen, 2506 Ford Dr.
Coulson, Mrs. Forest H., 1030 N. Henderson
Cozean, Mrs. Charles, 1548 Oak Lei
Crowe, Mrs. John, 1000 N. Henderson
Dinkins, Mrs. James, 1323 Perryville Rd.
Downey, Mrs. Patrick, 3218 Kage Hills
Edwards, Mrs. Don, 2530 Jonquil La.
Elrod, Mrs. Dennis, 2500 Fairlane
Essmeyer, Mrs. Joe, Rt. 2, Box 533-A
Estes, Mrs. Albert, 714 Broadway
Herbert, Mrs. Charles, 648 Sylvan La.
Holcomb, Mrs. John K., Rt. 1
Horne, Mrs. Paul, 1909 Huntington
Hunt, Mrs. Robert, 2021 Sherwood Dr.
Jaeger, Mrs. J. M., Shady La., Jackson 63755
Johnson, Mrs. Earl, 1044 N. Henderson
Johnson, Mrs. E. D. Jack, 1742 Lake Shore Dr.
Jones, Mrs. David N., 3222 Lakewood Dr.
Jung, Mrs. Marshall, Box 427, Illmo 63754
Kasten, Mrs. Melvin, 1209 Sailor Circle
Kinder, Mrs. James, Rt. 1, Box 135
Kinder, Mrs. Jerry L., 2426 Brookwood
Koldys, Mrs. Kenneth, 2460 Fairview
Kratz, Mrs. Paul, 1720 Cecilia
Lovinggood, Mrs. Thomas, 2505 Allendale Dr.
Magaletta, Mrs. George, 957 Rodney Dr.
McDonald, Mrs. Eugene, 225 W. Main, Jackson 63755
McGinty, Mrs. Charles, 2918 Independence
Nunnelly, Mrs. Gordon, 1432 Themis
Oehler, Mrs. William, 1001 N. Henderson
Otto, Mrs. Thomas, 511 Alta Vista
Parsons, Mrs. Leroy, Chateau Oaks
Rapp, Mrs. Harold, 1011 N. Henderson
Rawlins, Mrs. Fred, 1607 Bertling
Ridings, Mrs. Harold, 1607 Bertling
Ritter, Mrs. Carl, 1257 Rockwood
Ritter, Mrs. C. J., 2028 Concord
Ritter, Mrs. Raymond A., 2408 Terry Hill
Seabaugh, Mrs. Loy R., 811 E. Rodney
Shoss, Mrs. Milton, Rt. 1
Sparkman, Mrs. Thomas, 1629 Oxford Dr.
Spence, Mrs. Paul, 2530 Timber La.
Stewart, Mrs. Wendell, 2550 Allendale
Talbert, Mrs. Clifford, 1947 Robin Hood Circle
Terry, Mrs. James W., 2122 Woodhaven
Tygett, Mrs. Joe, 2122 Woodhaven
Weeks, Mrs. George, 1814 Scott's La.
Wilson, Mrs. Charles, Oak Lei Dr.
Wolff, Mrs. Paul G., 90 E. Cape Rock Rd.

CLAY COUNTY
(Kansas City)

Adams, Mrs. Howard, 1905 Snow Drop Circle, Liberty 64068
Allan, Mrs. James, 1015 Forest La., Liberty 64068
Allen, Mrs. Louis, 501 S. Woodland Dr. 64118
Armstrong, Mrs. Jay, 4812 Black Swan Dr., Shawnee Mission, Kan. 66216
Arst, Mrs. Herbert E., 1201 NE 81st 64118
Balhuizen, Mrs. John, 600 N.W. 42nd Terr. 64116
Bates, Mrs. G. Comer, 102 E. 43rd N. 64116
Boone, Mrs. Daniel C., 5800 N. Grand 64116
Bowles, Mrs. Richard, 414 N. Ridge, Liberty 64068
Burk, Mrs. E. K., 630 N.W. 42nd Terr. 64116
Castillo, Mrs. Michael, 530 N.W. 43rd Terr. 64116
Chastian, Mrs. Maurice W., 3[illegible] N.E. 47th 64116
Chiles, Mrs. David, 405 Maple, Smithville 64089
Cook, Mrs. Jerry W., 6904 N. Dawn La. 64151
Del Muro, Mrs. F., 5902 N. Poplar Dr. 64118
Denton, Mrs. Robert, 716 Manzonola, Smithville 64089
Dernoncourt, Mrs. John, 603 Quincy, Smithville 64089
Devine, Mrs. Mark W., 6910 Overhill Rd., Shawnee Mission, Kan. 66208
Dolan, Mrs. C. Terrance, Rt. 2, Smithville 64089
Dy-Ragos, Mrs. Ramon R., 5432 N.W. 70th, 64151
Edwards, Mrs. Theodore, 512 N.W. [illegible]3rd Terr. 64116
Fakhoury, Mrs. Donald A., 4332 N. Central 64116
Fischer, Mrs. Edward, 4218 N.W. Briarcliff La., 64116
Fischer, Mrs. Jose, 8515 W. 71st, Shawnee Mission, Kan. 66204
Flanders, Mrs. Virgil E., 2002 W. 91st, Leawood, Kan. 66206
Fotopoulos, Mrs. Chris, 2917 Cheyenne Circle 64116
Fowler, Mrs. I. Charles, 700 E. Barnes Ave. 64118
Gauer, Mrs. Robert J., 525 N.W. 43rd Terr. 64116
Gilani, Mrs. Abdallah, 418 Kingsley, Liberty 64068
Haley, Mrs. Ted M., 4121 N. Briarcliff Rd. 64116
Hayes, Mrs. Lawrence L., 440 N. Woodland Dr. 64118
Hedges, Mrs. Richard, 1017 Southwind Dr., Excelsior Springs 64024
Hodge, Mrs. Robert H., 2204 N.E. 39th 64116
Huddleston, Mrs. Harvey, 6 Marisa, Smithville 64089
Ise, Mrs. Frank, 6700 W. 66th Terrace, Shawnee Mission, Kan. 66202
King, Mrs. Phillip, 529 Fairview, Liberty 64068
Kirkland, Mrs. Jerry, 6604 N.W. Overland Dr. 64151
Kuenzi, Mrs. Donald E., 924 S. Woodland Dr. 64118
Langhus, Mrs. Melvin, 104 W. Englewood Dr. 64118
Lanning, Mrs. R. James, 3801 N. Central, 64116
Littlejohn, Mrs. Robert, 5215 W. 63rd Terr., Shawnee Mission, Kan. 66208
McCluggage, Mrs. Newt C., 418 N.W. 43rd Terr. 64116
McCormick, Mrs. James, 309 Northcrest Dr. 64116
McPhee, Mrs. William R., 1205 W. 76th 64114
Negrette, Mrs. Abelardo, 6932 Marty, Overland Park, Kan. 66204
Parker, Mrs. Robert H., 112 E. 43rd N. 64116
Perico, Mrs. Carlos, 8446 Juniper, Prairie Village, Kan. 66027
Pileggi, Mrs. Felix A., 424 W. Briarcliff Rd. 64116
Purcell, Mrs. Paul, 4 Carver, Smithville 64089
Reeder, Mrs. Charles C., 3 Maple Circle, Smithville 64089
Revare, Mrs. Paul, 3245 Chippewa Dr. 64116
Robinson, Mrs. Van M., 415 N.W. Briarcliff Ct. 64116
Schertz, Mrs. Truman B., 428 N.W. Briarcliff Rd. 64116
Schultz, Mrs. Robert, 1532 N. Withers Rd., Liberty 64068
Schutz, Mrs. John P., 304 Virginia, Excelsior Springs 64024
Slaughter, Mrs. Carl, 1001 N. Woodland 64118
Somoza, Mrs. Jose, 15 N.E. Hill 64116
Soper, Mrs. William, 203 Garden La, Excelsior Springs 64024
Spelman, Mrs. Arch E., 500 N. Bridge, Smithville 64089
Sportsman, Mrs. Weldon L., Rt. 2, Smithville 64089
Startman, Mrs. Clarence A., 405 N.W. 53rd, Kansas City 64118
Thomas, Mrs. Anthony, 940 N. Woodland Dr., Kansas City 64118
Triplett, Mrs. Daniel A., 936 Scott Dr., Liberty 64068
Underwood, Mrs. J., III, 3529 N.E. 48th Terr., Kansas City 64119
Vilmer, Mrs. Charles E., 6209 W. 65th, Shawnee Mission, Kan. 66202
Wald, Mrs. Donald, 1608 E. 69th N., Gladstone 64118
Waterman, Mrs. Franklin M., 420 Glendale Rd., Liberty 64068
Werner, Mrs. Dean F., 4609 N. Main 64116
Werner, Mrs. Franklin C., 422 Sagamore La. 64116
Williams, Mrs. R. D., 6533 Rainbow, Shawnee Mission, Kan. 66208
Withrow, Mrs. John B., 3925 N. Main 64116
Workman, Mrs. Charles E., 6609 Milhaven Dr., Shawnee Mission, Kan. 66202
Wright, Mrs. Earl, 8196 N.W. Kirkwood Dr. 64151

COLE COUNTY
(Jefferson City 65101)

Allen, Mrs. James Edwin, 846 Crestmere
Belden, Mrs. E. A., 2124 Lowell
Bowe, Mrs. Ted, 2503 Schellridge Dr.
Bradley, Mrs. William, 1705 Greenberry Rd.
Bregant, Mrs. Robert, 3435 Country Club Dr.
Busby, Mrs. William E., 523 Mesa
Courter, Mrs. Larry, Rt. 4
Cox, Mrs. William A., 812 Swifts Highway
Davidsson, Mrs. Walter F., 225 Fredericks La.
Dorris, Mrs. Richard P., 1611 Ridgewood
Enloe, Mrs. L. David, 1200 Moreland
Exon, Mrs. C. Stuart, 916 Boonville
Files, Mrs. James, 330 Sterling Price Rd.
Fullgrabe, Mrs. Emil A., 1914 Green Meadow Dr.
Garner, Mrs. Lynn M., 403 Meier Dr.
Garner, Mrs. Royal, Holts Summit 65043
Gordon, Mrs. James, 600 Boonville Rd.
Gove, Mrs. Herman S., 712 Broadway
Guhleman, Mrs. Henry V., Jr., 2018 Greenberry Rd.
Gurnee, Mrs. Landon, 2941 Country Club Dr.
Handler, Mrs. Fred P., 614 Boonville Rd.
Hauser, Mrs. Robert, Schott Rd.
Kanagawa, Mrs. Harold Hajime, 816 Houchin
Kanagawa, Mrs. Harold K., 314 Crest Dr.
Kelly, Mrs. Marshall W., 1916 Greenberry Rd.
Klebba, Mrs. Larry, 3300 Country Club Dr.
Leslie, Mrs. James T., 1824 Brookside Blvd.
Loyd, Mrs. Earl L., Riveria Heights, Holts Summit 65043
Matthews, Mrs. John I., 1314 Moreau Dr.
McHaney, Mrs. John W., 1819 Brookside
McKnelly, Mrs. William, 1106 Lee
Meier, Mrs. Francis X., 1913 Hayselton Dr.
Meinershagen, Mrs. Charles W., 138 Forest Hill
Ossman, Mrs. Julian A., 2407 W. Main
Ringo, Mrs. Henry, Centertown 65023
Robb, Mrs. Harold, 1117 Leslie Blvd.
Russell, Mrs. Joseph P., 1717 Greenberry Rd.
Ryan, Mrs. Thomas J., 1109 Moreau Dr.
Sanders, Mrs. Jack Shelby, 1820 Brookside Blvd.
Schmidt, Mrs. Jerome H., 806 Boonville
Schokker, Mrs. Johannes, 3463 Hobbs La.
Scott, Mrs. David, 957 Westwood
Sennott, Mrs. John Stephen, 123 Douglas Dr.
Shull, Mrs. G. Donald, 1925 Hayselton Dr.
Siu, Mrs. Kenneth C., 1009 Fairmount Blvd.
Stauffer, Mrs. Harry Beach, 830 Boonville Rd.
Stricker, Mrs. Harold C., 1205 Moreau Dr.
Sugarbaker, Mrs. Everett D., 2113 W. Main
Summers, Mrs. Joseph, Jr., 2313 W. Main
Tanner, Mrs. Robert, 1910 Greenberry Rd.
Taylor, Mrs. Leon, 1104 W. Main
Tietjen, Mrs. Fred, 7 Greentree Rd.
Van Vranken, Mrs. Eugene E., 2037 Tower Dr.
Wallace, Mrs. John R., 220 Ridgeway
Watts, Mrs. Byron Edward, 2112 Forest Dr.
Werth, Mrs. Joseph A., 325 Old Gibler Rd.

COOPER COUNTY
(Boonville 65233)

Abele, Mrs. William Arved, Krohn Dr.
Avery, Mrs. Willard Bartlett, 10 Oak Valley Rd.
Diekroeger, Mrs. Manuel Louis, Rt. 2
Hata, Mrs. Daikichi, 7 Morningside Dr.
Humphreys, Mrs. Ed. Tristran, 1123 3rd
Stuart, Mrs. Byron McClellan, 910 Shamrock Terr.
Winn, Mrs. George Warren, 607 Poplar
Ziegler, Mrs. William Henry, Weylan Dr.

DUNKLIN COUNTY
(Kennett 63857)

Benson, Mrs. Leo J., Jr., 204 Wiggs
Cash, Mrs. Charles R., 1112 White Oak Pl.
Croom, Mrs. D. W., Malden 63863
Dunmire, Mrs. George, 504 S. Baker Dr.
English, Mrs. W. D., Cardwell, Mo.
Garrison, Mrs. Norman A., Jr., 1009 S. Jackson
Legan, Mrs. John K., 617 Butler Dr.
Miltenberger, Mrs. Paul C., 705 W. Washington
Moorehead, Mrs. Wm. E., Malden 63863
Palenske, Mrs. R. L., Hornersville 63855
Peck, Mrs. C. R., 234 S. Main
Pu, Mrs. Pin H., 1105 W. 8th
Santos, Mrs. R. J., 1106 Kenwood
Sisler, Mrs. Maynard L., 411 Michael
Tarver, Mrs. Quinton, 1004 W. Washington
Wilson, Mrs. L. C., 915 S. Jackson
Zimmerman, Mrs. Joe A., 1105 White Oak Pl.

FRANKLIN-GASCONADE-WARREN COUNTIES

Baker, Mrs. Donald, 900 Clearview Dr., Union 63084
Bonney, Mrs. Samuel C., 2 Southpoint Pl., Washington 63090
Bozzo, Mrs. Raymond J., 6 Catawba Pl., Washington 63090
Brenner, Mrs. Paul A., 108 W. Washington Ave., Owensville 65066
Eisenmann, Mrs. Benjamin, New Haven 63068
Farrell, Mrs. S. L., 205 Elm, Washington 63090
Hoelscher, Mrs. H. F., Hickory Haven, Warrenton 63383
Moellenhoff, Mrs. Robert, 2315 E. 5th, Washington 63090
Muench, Mrs. Ludwig, 1530 Riverview Dr., Washington 63090
Post, Mrs. John R., Post Dr., Washington 63090
Richardson, Mrs. G. A., Union, Mo. 63084
Richardson, Mrs. W. R., 301 Hwy. 50 West, Union 63084
Schmidt, Mrs. Charles, Box 143, Gerald 63067
Strehlman, Mrs. Benjamin G., 510 West End, Union 63084

GRAND RIVER COUNTIES
(Caldwell-Carroll-Livingston-Grundy-Davies-Harrison-Linn-Mercer-DeKalb Counties)

Allen, Mrs. E. W., 1202 N. Jefferson, Carrollton 64633
Atcheson, Mrs. Windsor, 108 Kavanaugh, Trenton 64683
Bales, Mrs. Eugene, 502 W. 3rd Terr. Carrollton 64633
Bohnsack, Mrs. Ralph, 635 Skyline Dr., Brookfield 64628
Broyles, Mrs. Watkins, Bethany 64424
Cofer, Mrs. Thomas, 1721 Fair, Chillicothe 64601
Conrad, Mrs. Joseph, 1202 Jackson, Chillicothe 64601
Cross, Mrs. Albert, 1903 Moberly Rd. Trenton 64683
Daley, Mrs. Frank, 508 E. Samuel, Hamilton 64644
Dixon, Mrs. John, 1005 Brookfield, Brookfield 64628
Dowell, Mrs. Donald, 1830 Calhoun, Chillicothe 64601
Ellsworth, Mrs. Willard, Cainsville 64632
Fair, Mrs. William, 1705 Calhoun, Chillicothe 64601
Fuson, Mrs. William, 520 Pleasant View, Trenton 64683
Gale, Mrs. Joseph, 1710 Polk, Chillicothe 64601
Galvez, Mrs. Sisenando Patino, Santa Fe St., Marceline 64658
Gearhart, Mrs. Merriam, 2100 Beekman, Bethany 64424
Howell, Mrs. Billy, Rt. 1, St. Catherine 64677
Mandler, Mrs. George, 1616 Clay, Chillicothe 64601
Platz, Mrs. John, 804 N. Main, Carrollton 64633
Rose, Mrs. John F., 1024 Grandview, Chillicothe 64601
Ryan, Mrs. David, 1808 Hillcrest, Trenton 64683
Trinidad, Mrs. Hermanito, 1324 Dorney Dr., Chillicothe 64601
Vandiver, Mrs. V. D., Rt. 2, Chillicothe 64601
Yoon, Mrs. Jin Soo, 1500 Burnam Rd., Chillicothe 64601

GREENE COUNTY
(Springfield)

Allen, Mrs. Jerry, 1324 S. Fairway Terr. 65804
Allison, Mrs. James B., 2507 S. Luster 65804
Ancheta, Mrs. A. A., 2024 E. Rosebrier 65804
Anthony, Mrs. Dallas, 1322 S. Pickwick 65804
Ash, Mrs. Charles J., 743 Riverside 65804
Ashley, Mrs. Thomas, 2740 Pythian 65802
Atkinson, Mrs. Thomas, Rt. 9, Box 81-A 65804
Auner, Mrs. Cecil R., 649 McCann 65804
Back, Mrs. Donald, 2852 S. Glendale 65804
Bailey, Mrs. Alan, 2242 Barataria 65804
Baldwin, Mrs. Richard, 2033 Prairie La. 65804.
Barnhill, Mrs. Floyd, 3215 Bellhurst 65804
Beisner, Mrs. Don, 1512 Charing Rd. 65804
Benson, Mrs. Ronald, 4372 Valley Dr. 65804
Bentley, Mrs. John, 2830 S. Chantilly 65804
Blades, Mrs. Ross, 2308 Barataria 65804
Bonebrake, Mrs. McDonald, 1443 S. Delaware 65804
Boone, Mrs. Martin, Rt. 2, Box 315 65802
Brent, Mrs. Lanny, 4430 S. Pratt 65804
Broaddus, Mrs. Loren, 2425 Barataria 65804
Brown, Mrs. David, 2911 Melbourne Rd. 65804
Brown, Mrs. Lyman, 1410 N. Rogers 65802
Burkey, Mrs. Jordon, 2405 Sheridan 65804
Busiek, Mrs. Urban, 1635 E. Walnut 65802
Callaway, Mrs. Guy, Jr., 901 E. Portland 65804
Carr, Mrs. Phillip, 1260 E. Catalpa 65804
Cheek, Mrs. Anne, 1535 E. Meadowmere 65804
Cheek, Mrs. James W., 2342 Fritts La. 65804
Ciccone, Mrs. Pasquale, U. S. Medical Center 65804
Clarke, Mrs. Michael, Rt. 1, Box 442-A 65803
Clary, Mrs. Wm. W., 2259 Mirabeau 65804
Clawson, Mrs. J. W., 2257 Rosebrier 65804
Cochran, Mrs. Thomas, 2423 Brentwood 65804
Coller, Mrs. Frederick, 2433 S. Marlan 65804
Cooper, Mrs. C. Wesley, 2266 S. Inglewood 65804
Cordonnier, Mrs. James K., 2320 E. Rosebrier 65804
Corry, Mrs. Francis, 2461 Catalina 65804
Cox, Eleanor, 1072 Roanoke 65804
Crawford, Mrs. Oral, Rt. 1, Box 443 65803
Crighton, Mrs. John C., 3419 Weaver Rd. 65804
Cunningham, Mrs. D. Dean, 1425 S. Delaware 65804
Dillard, Mrs. Erin M., Rt. 9, Box 425-B 65804
Dolan, Mrs. Daniel, 2413 Claremont 65804
Domann, Mrs. Darrel, 4305 Ridgeview Rd. 65804
Duncan, Mrs. Robert, 1234 E. Loren 65804
Elkadi, Mrs. Ahmed, 2524 Barataria 65804
Ellis, Mrs. Francis, 2235 E. Glenwood 65804
Ellis, Mrs. Harry L., 2375 E. Rosebrier 65804
Evans, Mrs. E. L., 2457 E. Baratara 65804
Farthing, Mrs. Gene, 1235 E. Walnut 65802
Ferguson, Mrs. John, 1219 S. Clay 65804
Ferguson, Mrs. Lynn, 4111 Ridge Dr. 65804
Fessenden, Mrs. Ersel, 634 E. Kingsbury 65804
Fitch, Mrs. Max, 2523 S. Marlan 65804
Fogle, Mrs. Phillip, 2140 S. Meadowview 65804
Francis, Mrs. William, 2820 E. Glenwood 65804
Freeman, Mrs. S. F., 1339 S. Pickwick 65804
Gaska, Mrs. Walter, 2503 Collison 65804
Gentry, Mrs. Michael A., 2151 E. Rosebrier 65804
Gerdes, Mrs. John, 3041 Lamonta 65804
German, Mrs. Walter A., Jr., 2971 Southern Hills Blvd. 65804
Giddings, Mrs. Frank, 1211 S. Pickwick 65804
Giffin, Mrs. James, Rt. 2, Box 91 65804
Glynn, Mrs. Robert, 1101 Benton Ave. 65802
Gorelick, Mrs. David, 1041 Linwood Terr. 65804
Gose, Mrs. Don F., 1339 S. Delaware 65804
Hall, Mrs. David, Rt. 2, Rogersville 65742
Hall, Mrs. Durward, 2442 S. Fremont 65804
Hamburg, Mrs. Fredrick, 2757 E. Normandy 65804
Hanan, Mrs. Ernest, 724 E. Kingsbury 65804
Harmon, Mrs. Ben, Rt. 1, Nixa 65714
Harrison, Mrs. S. W., 3031 Shalimar 65804
Harvey, Mrs. Harold, 2531 Brentwood 65804
H'Doubler, Mrs. Alice, Rt. 7, Box 207, 65802
H'Doubler, Mrs. Charles E., 1421 Bedford Rd. 65804
H'Doubler, Mrs. F. T., Jr., 2445 Melbourne Rd. 65804
H'Doubler, Mrs. Peter, 1137 S. Pickwick 65804
Herfkens, Mrs. Kenneth, 2818 Natural Bridge 65804
Hills, Mrs. Joe E., 2917 Natural Bridge 65804
Holland, Mrs. Robert, 2225 E. Edgewood 65804
Hollis, Mrs. Richard, 2236 Englewood Rd. 65801
Holmes, Mrs. Daniel E., Rt. 9, 4318 Sunset 65804
Holmes, Mrs. David R., 2539 Melbourne Rd. 65804
Huewe, Mrs. Douglas, 2204 Clairborne 65804
Ivy, Mrs. H. Berry, 215 E. Sunshine 65804
Jobe, Mrs. Charles, 2415 E. Edgewood 65804
Johnson, Mrs. Fritz, 2435 E. Cambridge 65804
Johnson, Mrs. George, 2349 E. Edgewood 65804
Johnson, Mrs. Joseph C., Jr., 2240 Cherryvale 65804
Johnson, Mrs. Warford B., 2244 Edgewood 65804
Johnson, Mrs. William, 973 E. Linwood Dr. 65804
Johnston, Mrs. Joseph, 2855 Southern Hills Blvd. 65804
Jones, Mrs. Harold, 3042 Ridge Dr. 65804
Kev, Mrs. James 2278 Inglewood 65801
Klingner, Mrs. George, Turners 65765
Klingner, Mrs. George, Jr., Rt. 3, Box 202, Rogersville 65742
Knabb, Mrs. Kenneth, 1229 E. Catalpa, 65804
Kolze, Mrs. Vernon, 2519 S. Marlan 65804
Krahn, Mrs. Henry, 1415 Essex 65804
Langston, Mrs. W. Roland, 1453 S. Fairway 65804
LeFevre, Mrs. Philip, 2851 E. Covington Circle 65804
Lemmon, Mrs. G. Bruce, 1462 Virginia 65804
Lewis, Mrs. Noel, Rt. 1, Strafford 65757
Litton, Mrs. Lyle, 3044 Shalimar 65804
Lockhart, Mrs. Charles, 1600 E. Catalpa 65804
Loeb, Mrs. Richard, 4133 Ridge Dr. 65804
Lorenc, Mrs. Ernest, 2819 Canyon Dr. 65804
Lovett, Mrs. Robert L., 2850 Versailles 65804
Lowe, Mrs. Arch, 1700 E. Walnut 65806
Maddux, Mrs. Wm., 2634 Inglewood Rd. 65804
Maple, Mrs. Francis, 2115 Edgewood 65804
Maple, Mrs. Ruth, 885 S. Salt Pond., Apt. 14, Marshall 65340
McAlhany, Mrs. Howard, 1643 E. Catalpa 65804
McKinsey, Mrs. John, 2802 Natural Bridge 65804

McLaughlin, Mrs. Richard, 1021 E. Woodland 65804
Menchetti, Mrs. Don E., Rt. 9 Box 425-A 65804
Mentgen, Mrs. Carl, 3317 Southlyn Pl. 65804
Michael, Mrs. Harvey, 2847 S. Chantilly 65804
Milne, Mrs. Jay L., 2947 Whiteoak Dr. 65807
Moore, Mrs. DeArmond, 2306 S. Meadowview 65804
Moseley, Mrs. F. Thomas, 2837 Lomita Circle 65804
Napper, Mrs. Marvin, Rt. 1, Box 80A, Ash Grove 65604
Neu, Mrs. Leo T., 3008 Carlisle Circle 65804
Olson, Mrs. E. Rule, 2645 Wildwood Rd. 65804
Overend, Mrs. Don, 3020 Ridge Dr. 65804
Palcheff, Mrs. Chris L., Rt. 9, Box 400-L 65801
Park, Mrs. William, 815 E. Portland 65804
Parlato, Mrs. George, 2204 Shady Glen 65804
Penninger, Mrs. William, 2246 Claiborne 65804
Peterson, Mrs. Stanley S., 721 E. Stanford 65804
Podrecca, Mrs. Guido, 2550 Brentwood Blvd. 65804
Powell, Mrs. Edwin, 1226 S. Weller 65804
Prater, Mrs. Bill George, 3000 Carlisle Circle 65804
Pruett, Mrs. Paul L., Rt. 9, Box 425 65804
Quinn, Mrs. Paul, 2857 Chantilly 65804
Rinker, Mrs. Carl T., 2930 S. Glendale 65804
Rising, Mrs. Dean, 2930 Rochelle 65804
Robinson, Mrs. Gary, 2117 E. Montclair 65804
Rosen, Mrs. Max, 900 E. Walnut 65806
Sala, Mrs. Jose, 2901 Utica 65804
Sauer, Mrs. Paul, Rt. 11, 65803
Shackter, Mrs. Bruce, 1538 Essex 65804
Schaeffer, Mrs. Edward, 2356 Wildwood Circle 65804
Schroff, Mrs. Carle H., 2448 E. Broadmoor 65804
Schwartz, Mrs. Eugene, 1315 E. Loren 65804
Schweitzer, Mrs. Fred, 2550 Luster 65804
Shane, Mrs. Ramon, 3165 Glenhaven 65804
Siceluff, Mrs. Joseph, Rt. 9 65804
Simpson, Mrs. E. L., 2133 Meadowview 65804
Snead, Mrs. William, 2532 Sheridan 65804
Spalding, Mrs. David, Rt. 1, Box 94A, Rogersville 65742
Stewart, Mrs. Robert, 2360 E. Grand 65804
Stufflebaum, Mrs. Robert, 2323 E. Rosebrier 65804
Sturtevant, Mrs. Harwood, 2859 Utica 65804
Sullivan, Mrs. Dan T., 2244 Cherryvale 65804
Sweeney, Mrs. Thomas, Rt. 1, Nixa 65714
Tarrasch, Mrs. Ernest, 2114 Langston 65804
Tendai, Mrs. Mark, 2244 Edgewater 65804
Terry, Mrs. James F., 2830 Chambery 65804
Thomasson, Mrs. David, 2311 E. Glenwood 65804
Tillman, Mrs. Walter, 1220 E. Loren 65804
Tombridge, Mrs. T. L., 2830 S. Marlan 65804
Trotter, Mrs. W. Yates, 1243 E. Catalpa 65804
Turner, Mrs. Glen, 1462 S. Dollison 65804
Vensel, Mrs. Lee H., 2255 Meadowview 65804
Waddell, Mrs. Kenneth, 1126 S. Kentwood 65804
Wakeman, Mrs. J. Newton, 1402 Meadowmere 65804
Wakeman, Mrs. J. Newton, Jr., 2251 E. Washita 65804
Walker, Mrs. William M., 2845 Southern Hills Blvd. 65804
Warres, Mrs. Herbert, 2614 Inglewood Rd. 65801
Webb, Mrs. Richard, 1243 E. Loren 65804
White, Mrs. R. Ned, 3634 Cherry 65804
Whitlock, Mrs. Courtney, 1340 S. Delaware 65804
Wilson, Mrs. Roy E., Rt. 1, Box 210-A, Rogersville 65742
Winsky, Mrs. Arlen, 3031 E. Rocklyn 65804
Wise, Mrs. Gordon, 2850 Southern Hills Blvd. 65804
Wittmer, Mrs. Samuel, 2314 E. Washita 65804
Wong, Mrs. George, 2908 Avalon 65804
Wooldridge, Mrs. Wilfred, 1126 E. Stanford 65804
Wyrsch, Mrs. Leo M., 2222 S. Meadowview 65804
Yancey, Mrs. Daniel, 1133 S. Weller 65804
Zahn, Mrs. Robert, 1030 Brookside 65807

JACKSON COUNTY
(Kansas City)

Abella, Mrs. Ben Z., 8967 E. 62nd Terr. 64133
Abrams, Mrs. Bernard M., 1021 W. 69th 64113
Ackerman, Mrs. Norman, 5300 W. 84th, Shawnee Mission, Kan. 66207
Adelman, Mrs. Arthur, 6305 Aberdeen, Shawnee Mission, Kan. 66208
Agee, Mrs. Loren Glenn, Rt. 1, Rantoul, Kan. 66079
Aks, Mrs. Daniel, 3100 W. 68th, Shawnee Mission, Kan. 66208
Alderman, Mrs. Thomas F., 309 E. 127th 64145
Allebach, Mrs. Hobart, 3020 W. 84th, Leawood, Kan. 66207
Altringer, Mrs. Arthur, 5630 Mission Dr., Shawnee Mission, Kan. 66208
Ammatelli, Mrs. F. J., 1235 W. 57th Terr. 64113
Anderson, Mrs. Richard, 1001 Romany Rd. 64113
Andrus, Mrs. Bailey C., 6508 Overbrook Rd., Shawnee Mission, Kan. 66208
Arbab, Mrs. Ali A., 2415 W. 67th, Shawnee Mission, Kan. 66208
Arms, Mrs. Arnold V., 302 W. 99th Terr. 64114
Asnani, Mrs. Mithlest, 4729 Mohawk Dr., Shawnee Mission Kan. 66205
Atcheson, Mrs. Bellfield, 2011 W. 70th Terr., Shawnee Mission, Kan. 66208
Atwell, Mrs. Floyd, 630 W. 60th Terr. 64113
Bachman, Mrs. Paul, 1206 W. Truman Rd., Independence 64050
Baer, Mrs. Alvin J., 5800 Howe Dr., Shawnee Mission, Kan. 66205
Balanoff, Mrs. Arnold Z., 2500 W. 71st, Shawnee Mission, Kan. 66208
Ballard, Mrs. V. Bryce, 6618 Rainbow, Shawnee Mission, Kan. 66208
Barelli, Mrs. Pat., 5609 Mission Dr., Shawnee Mission, Kan. 66208
Barker, Mrs. James, 8416 W. 88th Terr. Prairie Village, Kan. 66208
Barloon, Mrs. James, 612 E. 66th 64131
Barnard, Mrs. John, 825 W. 52nd 64112
Barnett, Mrs. Gordon, 6568 High Dr., Shawnee Mission, Kan. 66208
Barr, Mrs. Glenn A., 9615 Grandview Rd. 64137
Barry, Mrs. John, 5510 W. 84th, Shawnee Mission, Kan. 66207
Barry, Mrs. William, Sulgrave Apts., 121 W. 48th 64112
Basantz, Mrs. F. Victor, 2025 W. 91st, Shawnee Mission, Kan. 66206
Bass, Mrs. Walter R., 6415 Sterling 64133
Bauer, Mrs. L. W., 4818 W. 80th, Prairie Village, Kan. 66208
Bay, Mrs. Merrill R., Rt. 2, Box 440, Blue Spring 64105
Beatty, Mrs. Eugene, 4923 W. 96th Terr., Shawnee Mission, Kan. 66207
Becker, Mrs. Rolfe, 6501 Wenonga, Shawnee Mission, Kan. 66208
Bell, Mrs. William, 214 Oxford La., Lee's Summit 64063
Bennett, Mrs. J. D., 3216 W. 69th, Shawnee Mission, Kan. 66208
Benoit, Mrs. Hector W., Jr., 2501 W. 64th, Shawnee Mission, Kan. 66208
Benson, Mrs. William F., 1210 W. 58th 64113
Berenson, Mrs. Sheldon, 832 W. 63rd 64113
Berry, Mrs. Maxwell, Sulgrave Apts., 121 West 48th 64112
Bickley, Mrs. James E., 3004 W. 83rd Terr., Leawood, Kan. 66206
Biggs, Mrs. Alfred D., Jr., 6551 Wenoga Terr., Shawnee Mission, Kan. 66208
Bikales, Mrs. Victor, 5810 High Dr., Prairie Village, Kan. 66208
Black, Mrs. Eugene C., 3201 W. 67th, Shawnee Mission, Kan. 66208
Black, Mrs. Thomas C., 7929 Outlook, Shawnee Mission, Kan. 66208
Blim, Mrs. Richard Don, 2209 W. 68th, Shawnee Mission, Kan. 66208
Bohan, Mrs. Peter, 4545 Wornall Rd. 64111
Bordy, Mrs. Marvin, 1911 Romany Road, Shawnee Mission, Kan. 66208
Borenstine, Mrs. Joseph, 7307 Holmes 64131
Borsuk, Mrs. Gregory, 4153 Bryant Dr., Independence 64055
Botwin, Mrs. Arnold, 3600 W. 89th, Shawnee Mission, Kan. 66207
Bowser, Mrs. John, 3701 Madison 64111
Boyd, Mrs. George, 4810 W. 80th, Shawnee Mission, Kan. 66208
Boyer, Mrs. Philip A., Jr., 10246 Cedarbrooke La. 64131
Boylan, Mrs. Peter C., 3308 W. 87th, Shawnee Mission, Kan. 66206
Braby, Mrs. Howard, 512 Linwood Terr., Independence 64050
Brams, Mrs. Jack B., 5050 Oak 64112
Braverman, Mrs. Abe Elliott, 2701 W. 68th, Shawnee Mission, Kan. 66208
Brown, Mrs. Adrian J., 12 East 63rd 64113
Brown, Mrs. Elwyn S., 200 W. 115th 64114
Brown, Mrs. Menzie H., 9421 Ralston 64134
Brown, Mrs. William R., 8717 Rosewood, Shawnee Mission, Kan. 66207
Brumm, Mrs. L. W., 7421 Wyoming 64114
Buckner, Mrs. Robert, 3507 W. 87th, Leawood, Kan. 66206
Budke, Mrs. Harold A., 1219 W. 66th Terr. 64113
Buhler, Mrs. Victor, 5212 Belleview 64112
Bunting, Mrs. Williston, 1231 W. 62nd 64113
Burry, Mrs. V. Fred, 5213 Stanton Dr. 64133
Caffrey, Mrs. Raymond J., 1314 W. Red Bridge Rd. 64114
Campbell, Mrs. Frederick, 1032 W. 55th 64113
Campbell, Mrs. John, 6506 W. 51st, Shawnee Mission, Kan. 66202
Capps, Mrs. Eugene C., 7921 El Monte, Shawnee Mission, Kan. 66208
Carder, Mrs. George, 1011 Scott Dr., Liberty 64068
Carlson, Mrs. Hjalmar E., 2709 W. 66th, Shawnee Mission, Kan. 66208
Carmichael, Mrs. Francis, 5841 High Dr., Shawnee Mission, Kan. 66208
Caruso, Mrs. Alfred A., 2018 W. 70th Terr., Shawnee Mission, Kan. 66208
Case, Mrs. William F., 4913 W. 97th, Shawnee Mission, Kan. 66207
Casford, Mrs. Ralph, 1236 W. 72nd 64114
Cattaneo, Mrs. Ernest, 9200 Cherokee La., Shawnee Mission, Kan. 66206
Chambers, Mrs. James Q. Jr., 5500 Belinder Ave., Shawnee Mission, Kan. 66205
Chandler, Mrs. Robert A., 6435 Indian La., Shawnee Mission, Kan. 66208
Childs, Mrs. Richard, 5325 Mission Woods, Shawnee Mission, Kan. 66206
Clark, Mrs. Irving, 2811 Blue Ridge Ext., Grandview 64030
Cochrane, Mrs. Joseph, 7702 Kessler La., Shawnee Mission, Kan. 66204
Cockerell, Mrs. Sanford, 3501 S. Crysler, Independence 64050
Coffey, Mrs. Ralph R., 5211 Wornall Rd. 64112
Colom, Mrs. George A., 4002 W. 56th, Shawnee Mission, Kan. 66205
Coppinger, Mrs. Thomas A., 8 E. 55th Terr. 64113
Cotton, Mrs. Thomas R., 6908 Valley Rd. 64113
Cowan, Mrs. George, Lake Quivira, Kan. 66106
Cox, Mrs. Kenneth E., 5640 Pembroke La., Prairie Village, Kan. 66208
Crocker, Mrs. Albert, 2945 Indiana 64128
Crouch, Mrs. Thomas T., 6800 W. 66th Terr., Shawnee Mission, Kan. 66202
Curran, Mrs. Desmond, 6626 Wenonga Terr., Prairie Village, Kan. 66208
Curts, Mrs. Calvin, 5709 Metcalf Ct., Shawnee Mission, Kan. 66202
Dalton, Mrs. Timothy, 11841 Oak 64114
Davis, Mrs. Donald R., 2501 West 67th, Shawnee Mission, Kan. 66208
Davis, Mrs. Herbert, 4601 Holmes 64110
Davis, Mrs. Jack, 7110 Harecliff Dr. 64133
Davis, Mrs. Robert C., 333 W. Meyer Blvd., Apt. 614 Kansas City 64113
DeFeo, Mrs. Theodore, 4100 W. 90th Terr., Shawnee Mission, Kan. 66207
Demott, Mrs. John D., 4402 Homestead Dr., Prairie Village, Kan. 66208
Dempsey, Mrs. Herbert, 806 Chestnut, Lee's Summit 64063
Dennie, Mrs. Charles, 2600 Verona Rd., Shawnee Mission, Kan. 66208

Dimond, Mrs. E. Grey, 5650 Ward Parkway 64113
Dixon, Mrs. George, 10416 Mohawk La., Leawood, Kan. 66206
Dixon, Mrs. V. L., 2501 West Paseo 64108
Dlabal, Mrs. L. J., 3729 Blue Ridge Blvd., Independence 64052
Dodge, Mrs. Mark, 5820 State Line Rd., Shawnee Mission, Kan. 66208
Dorsch, Mrs. E. H., 3807 Woodland, Independence 64052
Drake, Mrs. Roy, 6600 Outlook, Shawnee Mission, Kan. 66202
Drisko, Mrs. Robert, 2100 Stratford Rd., Shawnee Mission, Kan. 66208
Durnell, Mrs. Monaford D., 308 Lincolnwood, Lee's Summit 64063
Edmonds, Mrs. D. D., 9009 Mission Rd., Leawood, Kan. 66206
Egea, Mrs. Fernando, 9916 Perry Dr., Overland Park, Kan. 66212
Eiseman, Mrs. Gustave, 6520 Overhill Rd., Shawnee Mission, Kan. 66208
Elias, Mrs. David J., 22 E. Tapawingo, Blue Springs 64015
Ellfeldt, Mrs. Howard, 8544 Roe Blvd., Prairie Village, Kan. 66207
Elliott, Mrs. R. Glenn, 6136 Reinhardt Dr., Shawnee Mission, Kan. 66205
Engleman, Mrs. Reinhold, 524 W. 119th Terr. 64145
Engelmann, Mrs. Calvin, 2000 W. 68th, Shawnee Mission, Kan. 66208
Erickson, Mrs. Samuel, 9800 Horton, Shawnee Mission, Kan. 66207
Eshelman, Mrs. A. D., 16705 Larkspur La., Independence 64055
Etzenhouser, Mrs. Merrill, 3318 Oxford, Apt. D., Independence 64052
Etzenhouser, Mrs. Russell, 1317 W. College, Independence 64050
Eubank, Mrs. Dillard, 6020 Elm 64133
Euhank, Mrs. Will, 6113 Lane 64133
Eubank, Mrs. William Y., 1020 W. 60th Terr. 64113
Evans, Mrs. Lawrence L., 1240 W. 69th Terr. 64113
Fairchild, Mrs. Robert C., 8425 Reinhardt La., Leawood, Kan 66206
Farley, Mrs. Claude C., 3312 W. 87th, Leawood, Kan. 66206
Farney, Mrs. Jacob P., 2721 W. 69th, Shawnee Mission, Kan. 66208
Farnsworth, Mrs. Jesse J., 5608 Fairway, Shawnee Mission, Kan. 66205
Feist, Mrs. William, 10618 W. 98th Terr., Shawnee Mission, Kan. 66214
Fitzgerald, Mrs. Robert H., 8505 Cherokee Pl., Shawnee Mission, Kan. 66206
Flanders, Mrs. Horace F., 5161 W. 75th, Shawnee Mission, Kan. 66208
Flatley, Mrs. John, 827 Huntington Rd. 64113
Flynn, Mrs. James, 5720 High Dr., Shawnee Mission, Kan. 66208
Folck, Mrs. William P., 5804 Linden Rd. N.W., Parkville 64152
Forman, Mrs. Louis, 2801 W. 67th, Shawnee Mission, Kan. 66208
Forsythe, Mrs. Lees C., 8614 Overhill Rd., Shawnee Mission, Kan. 66206
Forsythe, Mrs. Robert W., 6457 Verona Rd., Shawnee Mission, Kan. 66208
Fouts, Mrs. Dallas, Sr., Box 124, Lee's Summit 64063
Fowler, Mrs. Fred D., 1231 W. 56th 64113
Fowler, Mrs. James, 200 W. 53rd Terr. 64112
Fredeen, Mrs. Robert C., 5437 Canterbury Rd., Shawnee Mission, Kan. 66205
Frick, Mrs. J. Paul, 116 Huntington Rd. 64113
Friedman, Mrs. Morris L., 2516 W. 69th, Shawnee Mission, Kan. 66208
Fritzlen, Mrs. Thomas J., 825 W. 63rd 64113
Gainey, Mrs. Harold L., 4907 Sunset Dr. 64112
Ganley, Mrs. Wm. Coyle, 9927 Walnut Dr., Apt. 103 64114
Garner, Mrs. James H., Jr., 8000 Sagamore Rd., Shawnee Mission, Kan. 66206
Garrison, Mrs. Roy F., 404 W. 67th Terr. 64113
Gauthier, Mrs. Charles, 11319 Summit 64114
Geha, Mrs. Braham, 4 Wycklow, Shawnee Mission, Kan. 66207
Geiger, Mrs. W. A., Jr., 3506 W. 92nd Terr. Leawood, Kan. 66206
Gerdes, Mrs. Joseph, 1605 N.E. Redbud La. 64116
Gibson, Mrs. David M., 5318 Sunset Dr. 64112
Gilgore, Mrs. Alfred, 8935 Rosewood Dr., Shawnee Mission, Kan. 66207
Gillmor, Mrs. C. Stewart, 420 E. Armour 64109
Ginsberg, Mrs. Norman A., 1220 W. 67th 64113
Gist, Mrs. W. W., 1230 W. 66th 64113
Givler, Mrs. Robert L., 408 Hargis La., Belton 64012
Glasscock, Mrs. Ernest L., 6214 High Dr., Shawnee Mission, Kan. 66208
Goldman, Mrs. Stanley, 5734 Windson Dr., Shawnee Mission, Kan. 66205
Goldstein, Mrs. Marvin, 901 W. 113th Terr. 64114
Goodson, Mrs. W. H., Jr., 815 W. 59th 64113
Gordon, Mrs. Morris, 10527 Walnut Dr. 64114
Gottsch, Mrs. Joseph C., 7904 Granada, Prairie Village, Kan. 66208
Green, Mrs. John R., Jr., 3143 Santa Fe Terr., Independence 64055
Griffith, Mrs. John A., Jr., 6500 Granada Dr., Shawnee Mission, Kan. 66208
Growdon, Mrs. John A., 6508 Aherdeen Rd., Shawnee Mission, Kan. 66208
Guastello, Mrs. Mario, 7020 Overhill Rd., Shawnee Mission, Kan. 66208
Gullett, Mrs. Charles, 947 S. Shore Dr., Lake Waukomis 64151
Habib, Mrs. Henry, 440 E. 74th Terr. 64131
Hagar, Mrs. David, 8800 E. 62nd 64133
Hahn, Mrs. Fred, 12001 E. 48th Terr. 64133
Haight, Mrs. John M., 5609 Blue Ridge Blvd. 64133
Hall, Mrs. Ralph R., 3900 W. 57th, Shawnee Mission, Kan. 66205
Halperin, Mrs. Philip, 6715 W. 52nd, Mission, Kan. 66222
Hamlin, Mrs. Howard, 4017 W. 100th Pl., Shawnee Mission, Kan. 66207
Harrin, Mrs. William, 5800 High, Shawnee Mission, Kan. 66208
Hartwig, Mrs. Raymond, 5204 Pawnee Dr., Shawnee Mission, Kan. 66205
Hartwig, Mrs. Raymond, 3110 Tomahawk, Shawnee Mission, Kan. 66208
Hausheer, Mrs. Herman, 12900 E. 36th Terr., Independence 64050
Haynes, Mrs. Solon, 5306 Holmes 64110
Heilman, Mrs. Edward, 12309 Wenonga La., Shawnee Mission, Kan. 66209
Helman, Mrs. Richard, 6540 Wenonga Rd., Shawnee Mission, Kan. 66208
Herdoiza, Mrs. Alfonso W., 7015 W. 66th Terr., Shawnee Mission, Kan. 66202
Hervey, Mrs. William H., 5128 Clark Dr., Shawnee Mission, Kan. 66205
Hibbard, Mrs. Blaine, 2900 W. 53rd, Shawnee Mission, Kan. 66205
Hickerson, Mrs. William, 4207 S. Crysler, Independence 64050
Higgins, Mrs. Ronald A., 2000 Arno Rd., Shawnee Mission, Kan. 66208
Hill, Mrs. J. H., 8115 Meadow La., Leawood, Kan. 66206
Hink, Mrs. Fred, 524 Hardy, Independence 64053
Hoadley, Mrs. William D., 9625 Beverly, Shawnee Mission, Kan. 66207
Hodgson, Mrs. Frank, 1049 W. 55th 64113
Hoeper, Mrs. Samuel, Box 169, Grandview 64030
Hoffman, Mrs. Alan, 9400 Bales 64432
Hollinger, Mrs. Lloyd, 4403 W. 93rd Terr., Shawnee Mission, Kan. 66207
Hollweg, Mrs. Kenneth, 808 W. Meyer Blvd. 64113
Holton, Mrs. Edward, 2817 Westport Rd., Independence 64052
Huet, Mrs. Raul, 8632 Juniper La., Shawnee Mission, Kan. 66207
Hughes, Mrs. Michael, 9933 Catalina, Shawnee Mission, Kan. 66205
Hunkeler, Mrs. John D., 5421 Fairway Rd., Shawnee Mission, Kan. 66205
Hunt, Mrs. Claude J., 615 W. 56th 64113
Hunt, Mrs. Thomas, 6636 Ensley La., Shawnee Mission, Kan. 66208
Hunter, Mrs. Martin, 4100 W. 93rd, Shawnee Mission, Kan. 66207
Huse, Mrs. William J., II, 8713 Burch La., Shawnee Mission, Kan. 66207
Ingham, Mrs. Walton C., 9723 Overbrook Rd., Shawnee Mission, Kan. 66206
Irvine, Mrs. John, 2500 Red Bridge Terr. 64131
Irwig, Mrs. Fred, 5109 W. 87th, Shawnee Mission, Kan. 66207
Jacoh, Mrs. Walter, 5301 W. 83rd Terr., Shawnee Mission, Kan. 66207
Jacohs, Mrs. Morton, 6416 Verona Rd., Prairie Village, Kan. 66208
Jacobs, Mrs. Walter Harvey, 6656 Milhaven, Shawnee Mission, Kan. 66202
James, Mrs. Otis, 2810 W. 68th, Shawnee Mission, Kan. 66208
Janes, Mrs. Donald R., 4502 W. 82nd Terr., Shawnee Mission, Kan. 66208
Jenah, Mrs. Morteza, 5964 Overhill, Shawnee Mission, Kan. 66208
Johnson, Mrs. Dallas A., 5321 W. 69th Terr., Shawnee Mission, Kan. 66207
Johnson, Mrs. Joseph, 707 W. Montcrew Dr. 64114
Johnstone, Mrs. Paul N., 117 W. 69th Terr. 64113
Jonas, Mrs. Harry S., 11711 Markham, Independence 64052
Jones, Mrs. Gale O., 817 W. 61st Terr. 64113
Jones, Mrs. Samuel T., 9915 Cherokee La., Shawnee Mission, Kan. 66207
Jones, Mrs. T. Reid, 6341 Roe, Shawnee Mission, Kan. 66208
Justus, Mrs. John, 5521 Howe Dr., Shawnee Mission, Kan. 66205
Kahn, Mrs. Marvin, 8120 Granada, Shawnee Mission, Kan. 66208
Kanarek, Mrs. Joseph, 6112 W. 87th Terr., Leawood, Kan. 66206
Kandt, Mrs. Ray E., Jr., 8900 Maple Dr., Shawnee Mission, Kan. 66207
Kantor, Mrs. Samuel, 3604 W. 87th, Leawood, Kan. 66206
Katf, Mrs. Nichola Y., 11812 Central 64114
Kaufman, Mrs. Andrew, 4117 W. 94th Terr., Shawnee Mission, Kan. 66207
Kay, Mrs. Billy Franklin, 10326 Sagamore La., Leawood, Kan. 66206
Kayanan, Mrs. Jose, 2310 E. Meyer Blvd. 64132
Keeler, Mrs. James E., 422 E. Meyer 64131
Kelling, Mrs. Douglas, 7705 W. 102nd, Shawnee Mission, Kan. 66212
Kelly, Mrs. Joseph G., 3609 Delaware Dr., Independence 64055
Keltner, Mrs. Raymond, 8900 Pawnee La., Leawood, Kan. 66206
Kendall, Mrs. Charles A., 604 Red Rd., Independence 64055
Kendall, Mrs. Forrest Hardy, 2505 W. 71st, Prairie Village, Kan. 66208
Kennard, Mrs. G. Keith, 3658 Madison 64111
Kent, Mrs. Bela, 5839 Cherokee Dr., Shawnee Mission, Kan. 66205
Kettner, Mrs. Edward G., 6510 Milhaven, Shawnee Mission, Kan. 66202
Kiene, Mrs. Richard, 6429 Overbrook, Shawnee Mission, Kan. 66208
Killen, Mrs. Duncan, 1909 W. 70th, Shawnee Mission, Kan. 66208
Kindred, Mrs. Lynn, 4606 W. 82nd Terr., Prairie Village, Kan. 66208
Kitchen, Mrs. W. M., 2700 W. 68th, Shawnee Mission, Kan. 66208
Klein, Mrs. E. H., 7011 Roe, Prairie Village, Kan. 66208
Knight, Mrs. Lyle, 108 Madison La., Lee's Summit 64063
Knoch, Mrs. H. Kermit, 6606 Willow La., Shawnee Mission, Kan. 66208
Koontz, Mrs. Paul G., 301 W. 54th 64112
Kranson, Mrs. Seymour, 11 Hawthorne Pl., Independence 64052
Kurtz, Mrs. Karl, 10012 Wedd Dr., Shawnee Mission, Kan. 66212
Kuruvilla, Mrs. George, 11201 Jefferson 64114
Kyger, Mrs. John, 3612 Blue Ridge, Independence 64052
Lamar, Mrs. Robert F., 800 W. 53rd Terr. 64112
Lamhie, Mrs. Rodger W., 10317 Grant La., Shawnee Mission, Kan. 66212
Lampton, Mrs. Lawrence, 5515 Westover Rd. 64113
Landers, Mrs. Burnell, 13101 Delaware Dr., Independence 64055
Landis, Mrs. George K., 10115 Pawnce La., Shawnee Mission, Kan. 66206
Latham, Mrs. Raymond, 3008 W. 67th, Shawnee Mission, Kan. 66208
Layle, Mrs. John, 5500 Chadwick, Shawnee Mission, Kan. 66205
Layton, Mrs. Ira, 10004 Walnut Dr. 64114
Lee, Mrs. Henry, 9821 Sagamore Rd., Leawood, Kan. 66206

Lee, Mrs. King Y., 10811 W. 100 St. Terr., Shawnee Mission, Kan. 66214
Lemoine, Mrs. Albert, 9200 High Dr., Leawood, Kan. 66206
Lentz, Mrs. Clark, 2600 W. 69th, Shawnee Mission, Kan. 66208
Leo, Mrs. William, 4505 W. 66th, Prairie Village, Kan. 66208
Leonidas, Mrs. John, 13309 W. 83rd, Lenexa, Kan. 66215
Lieberman, Mrs. B. Albert, 1229 W. 67th 64113
Lindgren, Mrs. Carleton, 12805 E. 38th, Independence 64055
Link, Mrs. Vance, 1201 W. 36th, Independence 64050
Linville, Mrs. Howard, 9905 Cherokee La., Leawood, Kan. 66206
Long, Mrs. R. Stacy, 3343 Blue Ridge Blvd., Independence 64052
Lotito, Mrs. Carlos, 8916 Horton, Overland Park, Kan. 66207
Loutzenhizer, Mrs. James, 11405 Jefferson 64114
Lowell, Mrs. Paul, 4742 Liberty 64112
Lundgren, Mrs. Fred, Jr., 201 W. 116th 64114
Lyddon, Mrs. H. R., Jr., 1221 W. 67th 64113
Lytton, Mrs. George J., 617 W. 49th 64112
Maben, Mrs. Sam, 8954 E. 60th Terr. 64133
MacGee, Mrs. Edwin, 10921 W. 99th Pl., Shawnee Mission, Kan. 66214
MacNaughton, Mrs. Ralph E., 17 Wyklow, Overland Park, Kan. 66207
MacNaughton, Mrs. Robert, 3208 W. 101st, Shawnee Mission, Kan. 66206
Mallouk, Mrs. Alexander G., 6508 W. 102nd, Shawnee Mission, Kan. 66212
Mangels, Mrs. Kenneth A., Sr., 1103 W. 36th Terr., Independence 64055
Mantz, Mrs. Herbert, 1209 Romany Rd. 64113
Markel, Mrs. Larry Gene, 4504 W. 93rd, Shawnee Mission, Kan. 66207
Marks, Mrs. Mark M., 6537 Summit 64113
Martin, Mrs. Clyde, 5531 E. Mission Dr., Shawnee Mission, Kan. 66208
Masucci, Mrs. Joseph M., 11800 Washington 64114
Mayer, Mrs. John H., 1250 W. 67th Terr. 64113
Mayer, Mrs. John H., Jr., 5739 Windsor Dr., Shawnee Mission, Kan. 66205
McCallister, Mrs. Ben, 6431 Norwood, Shawnee Mission, Kan. 66212
McClanahan, Mrs. Robert, 6456 Overbrook Dr., Shawnee Mission, Kan. 66208
McConahay, Mrs. David, 3002 W. 67th Terr., Shawnee Mission, Kan. 66207
McConchie, Mrs. James E., Box 419, Rt. 1, Grain Valley 64029
McDonald, Mrs. Herbert, 435 W. 58th 64113
McDonnell, Mrs. John, 5411 Central 64112
McIntosh, Mrs. Donald E., 12709 Oakmont Dr. 64145
McKee, Mrs. Wallace, 2020 Stratford Rd., Shawnee Mission, Kan. 66208
McKnelly, Mrs. William V., Jr., 7228 Hadley, Shawnee Mission, Kan. 66204
McMillan, Mrs. Thomas, 8201 Dearborn, Shawnee Mission, Kan. 66208
McNabney, Mrs. W. Kendall, 5319 Oak 64112
Meegan, Mrs. Robert, 401 W. 119th Terr. 64145
Melgaard, Mrs. S. Ross, 1012 W. 61st 64113
Meyer, Mrs. Paul W., 5160 Sunset Dr. 64112
Meyers, Mrs. Harold, 1901 Brookwood Rd., Shawnee Mission, Kan. 66208
Miles, Mrs. George O., 2231 W. 63rd St., Shawnee Mission, Kan. 66208
Milgram, Mrs. Byron A., 1209 W. 66th Terr. 64113
Miller, Mrs. Gerald L., 836 W. 51st 64112
Miller, Mrs. Max I., 4001 W. 66th, Prairie Village, Kan. 66208
Miller, Mrs. Wilson Herrick, 6400 Verona Rd., Shawnee Mission, Kan. 66208
Mitchell, Mrs. Andrew, 4013 W. 73rd Terr., Shawnee Mission, Kan. 66208
Mitchell, Mrs. John D., 6104 Lockton La., Shawnee Mission, Kan. 66205
Mitra, Mrs. Nirmal, 2007 W. 81st Terr., Leawood, Kan. 66206
Mixson, Mrs. William C., 6501 Sagamore Rd., Shawnee Mission, Kan. 66208
Montello, Mrs. Samuel A., 4109 Delmar Dr., Prairie Village, Kan. 66208
Mooney, Mrs. Marcel L., 6439 Ensley La., Prairie Village, Kan. 66208
Moore, Mrs. Robert A., 10818 W. 102nd, Overland Park, Kan. 66214
Moreano, Mrs. Armando, 3920 W. 57th, Shawnee Mission, Kan. 66205
Morgan, Mrs. David, 6513 Jefferson 64113
Morgan, Mrs. William R., 9500 Russell, Shawnee Mission, Kan. 66207
Morris, Mrs. Joseph H., 5017 George 64133
Morrison, Mrs. J. Scott, 8932 Rosewood, Prairie Village, Kan. 66207
Morrow, Mrs. Raymond L., 17 W. 69th 64113
Mosbacher, Mrs. Hugh, 16509 E. 32nd, Independence 64055
Moss, Mrs. Paul, 8701 Walmer, Shawnee Mission, Kan. 66212
Mosser, Mrs. Robert, 8342 Carter, Overland Park, Kan. 66212
Mueller, Mrs. M. J., 11723 Central 64114
Mullen, Mrs. Leo M., 1900 W. 68th, Shawnee Mission, Kan. 66208
Murphy, Mrs. Robert J., 6428 High Dr., Shawnee Mission, Kan. 66208
Murray, Mrs. W. Lee, 16 Wycklow, Overland Park, Kan. 66207
Naime, Mrs. Mansour J., 9625 Linden Dr., Shawnee Mission, Kan. 66207
Nesselrode, Mrs. John H., 12000 Marbec Trail, Independence 64052
Neumann, Mrs. James W., 5850 Pembroke Ct., Shawnee Mission Kan. 66208
Newman, Mrs. Robert L., 1024 Huntington 64113
Nickson, Mrs. Charles E., Jr., 4425 Larson 64133
Noback, Mrs. R. K., 628 W. 67th 64113
Noltensmeyer, Mrs. Milton, 3305 W. 50th Terr., Shawnee Mission, Kan. 66205
O'Hearne, Mrs. John J., 5529 High Dr., Shawnee Mission, Kan. 66208
O'Neil, Mrs. James H., 2111 W. 69th Terr., Shawnee Mission, Kan. 66206
Overesch, Mrs. Harry B., 10804 Grandview Rd. 64137
Ozar, Mrs. Milton B., 1206 W. 62nd 64113
Padfield, Mrs. Earl G., 1900 W. 61st Terr., Shawnee Mission, Kan. 66208
Pakula, Mrs. Sidney F., 333 W. Meyer 64113
Pallett, Mrs. Harold A., 5000 Oak, Apt. 312 64112
Parker, Mrs. Hubert M., 1200 W. Red Bridge Rd. 64114
Pelegrin, Mrs. Robert J., 32 E. Concord 64112
Penner, Mrs. Stanley, 907 W. 101st Terr. 64114
Perico, Mrs. Carlos, 8446 Juniper, Shawnee Mission, Kan. 66207
Perll, Mrs. Maurice F., 830 W. 61st Terr. 64113
Perry, Mrs. Ralph, 7140 Sni-A-Bar Rd. 64129
Peterson, Mrs. Eugene G., 108 Hackberry (Lakewood), Lee's Summit 64063
Petersen, Mrs. George, 4806 W. 68th, Shawnee Mission, Kan. 66208
Pfeutze, Mrs. Edwin L., 5407 W. 100th Terr., Shawnee Mission, Kan. 66207
Piepergerdes, Mrs. Larry G., 1410 W. 5th, Lee's Summit 64063
Pinkerton, Mrs. Joseph, Jr., 2019 W. 70th Terr., Shawnee Mission, Kan. 66208
Piper, Mrs. Donald, 9929 High Dr., Shawnee Mission, Kan. 66206
Pollock, Mrs. Leo H., 6601 Wenonga Terr., Shawnee Mission, Kan. 66208
Poonawala, Mrs. Huseni, 901 E. 109th Terr. 64131
Preston, Mrs. Albert, Jr., 606 W. Meyer Blvd. 64113
Pugh, Mrs. Richard George, 102 Golfview Dr., Blue Springs 64015
Quer, Mrs. Erich A., 1901 Stratford Rd., Shawnee Mission, Kan. 66208
Raich, Mrs. Robert A., 828 Greenway Terr. 64113
Ramey, Mrs. Ehret O., 8108 Ward Parkway Plaza 64114
Rector, Mrs. Joe Lee, Jr., 3915 W. 53rd, Shawnee Mission, Kan. 66205
Reddin, Mrs. Jack, 219 Ponderosa, Lee's Summit 64063
Reed, Mrs. William, 5931 High Dr., Shawnee Mission, Kan. 66208
Reinhardt, Mrs. G. Robert, 1201 Romany Rd. 64113
Riller, Mrs. L. E., 1267 W. 61st 64113
Robinson, Mrs. Arthur W., 6600 Wenonga Rd., Shawnee Mission, Kan. 66208
Robinson, Mrs. Ernest Kipp, 1015 W. 58th Terr. 64113
Robinson, Mrs. William J., 9931 Lee Circle, Shawnee Mission, Kan. 66206
Robison, Mrs. James Travis, Jr., 4203 W. 92nd Terr., Shawnee Mission, Kan. 66207
Rodgers, Mrs. George H., 10041 El Monte La., Shawnee Mission, Kan. 66207
Rubin, Mrs. Harvey P., 4604 W. 87th Terr. Shawnee Mission, Kan. 66207
Rubin, Mrs. Sidney, 1287 W. 72nd 64114
Rubnitz, Mrs. Leon, 210 W. 94th 64114
Russell, Mrs. James, 1250 W. 56th 64113
Sabates, Mrs. Felix, 2503 W. 70th Terr., Shawnee Mission, Kan. 66208
Saferstein, Mrs. A. L., 6859 Cherry 64131
Sanders, Mrs. Donald, 11721 Oak 64114
Sanders, Mrs. William E., 1004 W. 66th Terr. 64113
Schaerrer, Mrs. W. C., 5245 Mercier 64112
Schiffmacher, Mrs. Jack E., 4517 W. 65th, Prairie Village, Kan. 66208
Schillie, Mrs. Gene A., 8232 Linden, Shawnee Mission, Kan. 66208
Schlozman, Mrs. Daniel, 9315 Lamar, Shawnee Mission, Kan. 66207
Schmidt, Mrs. C. Robert, 8726 Cherokee La., Leawood, Kan. 66206
Schoolmam, Mrs. Arnold, 8705 Catalina Dr., Shawnee Mission, Kan. 66207
Schottman, Mrs. Gerhard W., 5010 W 96th, Shawnee Mission, Kan. 66207
Seely, Mrs. Clark, 3000 W. 68th, Shawnee Mission, Kan. 66208
Seiden, Mrs. Gerald D., 2509 W. 71st, Prairie Village, Kan. 66208
Sells, Mrs. Kenneth J., 6220 Ensley La., Shawnee Mission, Kan. 66208
Shapiro, Mrs. L. M., 6429 Holmes 64131
Sheldon, Mrs. Russell D., 816 W. 58th Terr. 64113
Shifrin, Mrs. Alexander, 1027 W. 69th 64113
Shireman, Mrs. Kenneth, Noland Rd. & 55th Terr., Rt. 3 64133
Shmock, Mrs. Carlton, 3019 W. 84th, Shawnee Mission, Kan. 66206
Shuey, Mrs. Herbert, 933 E. 77th Terr. 64131
Simon, Mrs. Sanford, 5820 Mission Dr., Shawnee Mission, Kan. 66208
Sinclair, Mrs. Alexander B., Jr., 1230 W. 61st Terr. 64113
Sinclair, Mrs. Richard H., 3908 W. 91st, Shawnee Mission, Kan. 66207
Singleton, Mrs. Charles, II, 6518 Maple, Shawnee Mission, Kan. 66202
Skillman, Mrs. Robert K., 10335 High Dr., Shawnee Mission, Kan. 66206
Skinner, Mrs. John T., 824 Westover Rd. 64113
Slentz, Mrs. Edwin L., 4812 W. 66th Terr., Shawnee Mission, Kan. 66208
Slentz, Mrs. William A., 9835 Pembroke La., Shawnee Mission, Kan. 66206
Slickman, Mrs. Robert A., 4937 Wyoming 64112
Smith, Mrs. Arthur B., 8409 Wenonga Rd., Shawnee Mission, Kan. 66206
Smith, Mrs. Elbert E., III, 5847 Howe Dr., Shawnee Mission, Kan. 66203
Smith, Mrs. Othello D., 5400 W. 83rd, Shawnee Mission, Kan. 66208
Smith, Mrs. Wallace B., 3611 S. Delaware, Independence 64050
Spafford, Mrs. Allen, 5552 Belinder Ave., Shawnee Mission, Kan. 66205
Spalding, Mrs. Wilbur B., Jr., 6206 Robinson, Shawnee Mission, Kan. 66202
Spurny, Mrs. Otto M., 6400 Cherry 64131
Stacey, Mrs. Wallace R., 3407 Shady Bend Dr., Independence 64052
Staggs, Mrs. William A., 641 E. 45th 64110
Staley, Mrs. Harry R., 4740 Roanoke Parkway 64112
Stanley, Mrs. John, 5307 W. 100th St., Shawnee Mission, Kan. 66207
Statland, Mrs. Morris, 2911 W. 66th Terr., Shawnee Mission, Kan. 66208
Steffen, Mrs. L. F., 9548 Rosewood La., Shawnee Mission, Kan. 66207
Stelmach, Mrs. W. Jack, 4303 W. 93rd Terr., Shawnee Mission, Kan. 66207
Stockton, Mrs. Raymond, 5215 W. 81st, Prairie Village, Kan. 66208
Stockwell, Mrs. A. Lloyd, 5736 Windsor Dr., Shawnee Mission, Kan. 66205
Stribling, Mrs. Thomas L., 3808 S. Union, Independence 64055

Sutton, Mrs. Richard L., Jr., 5400 Ward Parkway 64112
Swerdlow, Mrs. Martin A., 517 W. 119th Terr 64145
Szabados, Mrs. Ernest D., 1901 S. Leslie, Independence 64050
Thalblum, Mrs. Harvey, 313 W. 99th 64114
Theel, Mrs. Otto, 5911 Howe Dr., Shawnee Mission, Kan. 66205
Thomas, Mrs. Christopher Y., Jr., 5830 Mission Dr., Shawnee Mission, Kan. 66208
Thompson, Mrs. C. Leslie, 1256 W. 61st Terr. 64113
Throne, Mrs. Elias M., 10621 W. 102nd, Overland Park, Kan. 66214
Tice, Mrs. Wayne K., 3504 S. Delaware, Independence 64050
Tillema, Mrs. David A., 8015 El Monte, Shawnee Mission, Kan. 66208
Totten, Mrs. Frederick E., 9331 Hayes Dr., Shawnee Mission, Kan. 66212
Toubes, Mrs. Daniel, 9718 Wenonga, Leawood, Kan. 66206
Troeh, Mrs. Richard, 13000 Delaware Dr., Independence 64055
Trowbridge, Mrs. E. H., Jr., 32 Compton Ct., Corinth Downs, Shawnee Mission, Kan. 66208
Tutera, Mrs. D. F., 1260 W. 63rd Terr. 64113
Twin, Mrs. Edward, 8208 Tomahawk, Shawnee Mission, Kan. 66208
Twyman, Mrs. Richard, 1020 W. 56th 64113
Underwood, Mrs. Dick Holland, 9828 Belinder, Shawnee Mission, Kan. 66206
Van Biber, Mrs. James T., 3705 Northern Blvd., Independence 64052
Van Thullenar, Mrs. Philip, 5000 Reinhardt Ave., Shawnee Mission, Kan. 66205
Vaughn, Mrs. James W., 5509 W. 86th, Shawnee Mission, Kan. 66207
Vera, Mrs. Enrique, 9218 W. 82nd Terr., Shawnee Mission, Kan. 66204
Vincent, Mrs. Jack C., 2003 W. 67th Terr., Shawnee Mission, Kan. 66208
Virden, Mrs. Herbert, 6533 High Dr., Shawnee Mission, Kan. 66208
Vogel, Mrs. Arthur P., 6524 Willow La., Shawnee Mission, Kan. 66208
Volk, Mrs. George E., 109 West 115th 64114
Voth, Mrs. Harold, 5413 Neosho, Shawnee Mission, Kan. 66205
Wade, Mrs. Frederick E., 413 W. 62nd 64113
Wagner, Mrs. Paul J., Greenwillow Farm, Rt. 1, Greenwood 64034
Walker, Mrs. John W., 10336 Mohawk, Shawnee Mission, Kan. 66206
Walker, Mrs. Orville C., 604 Partridge, Independence, Kan. 64050
Wall, Mrs. Leonard A., 5011 Neosho Ave., Shawnee Mission, Kan. 66205
Waltz, Mrs. Charles, 504 Wedgewood Dr., Blue Springs 64015
Waxman, Mrs. Herbert, 2012 W. 81st, Shawnee Mission, Kan. 66206
Weidmaier, Mrs. E. John, 36 N.E. 61st 64118
Weir, Mrs. Robert K., 10015 E. 36th, Independence 64052
Wells, Mrs. Donald E., 1-18 Lake Lotowana, Rt. 4, Lee's Summit 64063
Wheeler, Mrs. Charles B., 830 W. 53rd 64112
Wheeler, Mrs. John H., 5650 Mission Dr., Shawnee Mission, Kan. 66208
White, Mrs. Charles H., 6518 Overhill Rd., Prairie Village, Kan. 66208
White, Mrs. James S., 1105 Queens Pl. 64130
White, Mrs. Stoughton F., 6815 Cherokee La., Shawnee Mission, Kan. 66208
Whiteman, Mrs. John R., 9729 Cherokee La., Leawood, Kan. 66206
Whitmore, Mrs. J. Stewart, 1039 W. 58th 64113
Whitten, Mrs. John S., 3823 Trail Ridge, Independence 64055
Wicks, Mrs. Edwin O., 506 N.W. 43rd Terr. 64116
Wilber, Mrs. Robert D., 6056 Mission, Shawnee Mission, Kan. 66208
Wilhelm, Mrs. Warren F., 3100 W. 67th, Shawnee Mission, Kan. 66208
Wilkinson, Mrs. Charles B., 4604 Benton Blvd. 64130
Wilkinson, Mrs. E. A., 6810 Linden La., Prairie Village, Kan. 66208
Williams, Mrs. Frank, 5921 Ward Parkway 64113
Williams, Mrs. George P., 9413 Ralston 64138
Williams, Mrs. Joseph C., Jr., 2209 Arno Rd., Shawnee Mission, Kan. 66202
Williams, Mrs. Thomas A., 9601 Manor Rd., Leawood 66206
Williams, Mrs. Vincent T., 4400 Blue Ridge Blvd. 64133
Willoughby, Mrs. James W., 420 N. Ridge, Liberty 64068
Willoughby, Mrs. Jean B., 1019 W. 69th Terr. 64113
Winer, Mrs. Herbert J., 2103 W. 69th Terr., Shawnee Mission, Kan. 66208
Winer, Mrs. Nathaniel, 1007 Brentwood Circle 64112
Winston, Mrs. Bernard H., 1006 W. 67th 64113
Wise, Mrs. Morris F., 2610 W. 105th, Leawood, Kan. 66206
Wolf, Mrs. Jack, 6125 Morningside Dr. 64113
Woods, Mrs. S. Dwight, 3201 W. 68th, Shawnee Mission, Kan. 66208
Woods, Mrs. Walton C., 9004 E. 73rd, Raytown 64133
Wortmann, Mrs. Robert F., 2819 W. 66th Terr., Shawnee Mission, Kan. 66208
Wright, Mrs. R. Paul, 5715 Metcalf Ct., Shawnee Mission, Kan. 66202
Wu, Mrs. William, 4414 Homestead Dr., Prairie Village, Kan. 66208
Wurster, Mrs. Jerry B., 5218 W. 98th Terr., Shawnee Mission, Kan. 66207
Youll, Mrs. Donald V., 8711 Ensley La., Shawnee Mission, Kan. 66206
Young, Mrs. James E., 9700 Overbrook Rd., Leawood, Kan. 66206
Young, Mrs. J. W., 5443 Mohawk, Shawnee Mission, Kan. 66205
Zacharias, Mrs. David L., 7819 N.W. Westside Dr. 64152
Zahony, Mrs. Ivan, 8720 Rosewood, Shawnee Mission, Kan. 66207
Zoglin, Mrs. Nathan, 333 W. Meyer Blvd. 64113
Zoller, Mrs. David, 74 Lake Shore W., Lake Quivira, Kan. 66106

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(Joplin)

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Bentlage, Mrs. Charles H., 1304 Fairmont Dr. 64801
Bhend, Mrs. David, 2435 E. 12th 64801
Bird, Mrs. William, 2301 Texas 64801
Birsner, Mrs. Frank, 1717 River St., Carthage 64836
Bladow, Mrs. Terrence, 2703 Missouri 64801
Bopp, Mrs. Ronald, 505 Glenview 64801
Brandon, Mrs. Frederick, 2609 E. 12th 64801
Burch, Mrs. John E., 1345 Crest Dr. 64801
Butler, Mrs. Patrick, Rt. 1, Box 280, Diamond 64840
Carnes, Mrs. Victor, 1418 Crestwood Dr. 64801
Chase, Mrs. Ned B., 2931 Indiana 64801
Chesney, Mrs. George W., Jr., 2416 E. 12th 64801
Cohle, Mrs. Richard, 1609 Lilac La., Carthage 64836
Craig, Mrs. Irwin T., 2525 E. 12th 64801
Crawford, Mrs. A. L., 2931 Pearl Ave. 64801
Crispell, Mrs. Lawrence S., 911 Kensington 64801
Curl, Mrs. Howard, 2031½ Pearl 64801
Detar, Mrs. Burleigh, Sr., 410 Jackson 64801
Dixon, Mrs. Herbert, Rt. 2, Box 221 64801
Esther, Mrs. John R., 612 Glenview 64801
Ferguson, Mrs. Ralph, 420 E. 33rd 64801
Ferguson, Mrs. Robert M., 2319 E. 10th 64801
Fritsch, Mrs. Andrew J., 2920 Pearl 64801
Gardner, Mrs. Joe, 1002 N. Moffet 64801
Gaston, Mrs. Samuel, 2720 Ohio 64801
Hallaba, Mrs. Moheb, Rt. 2, Box 197-C 64801
Hamilton, Mrs. Eugene, 2736 E. 15th 64801
Hilton, Mrs. Paul, 1612 Murphy Blvd. 64801
Isbell, Mrs. C. H., 1046 S. Garrison, Carthage 64836
Jeans, Mrs. Virgil, 660 Jaccard Pl., Joplin 64801
Kirkman, Mrs. Robert E., 2504 E. 10th 64801
Koehler, Mrs. John W., 1001 Manitou 64801
Longenecker, Mrs. J. L., 2606 E. 14th 64801
MacLaughlin, Mrs. James, 728 N. Pearl 64801
Maddox, Mrs. John D., 1330 Crest Dr. 64801
Martin, Mrs. Clarence, 2419 E. 10th 64801
McGonigle, Mrs. James Patrick, 1037 Campbell Parkway 64801
McPike, Mrs. Lloyd H., 2217 Brownell 64801
Mueller, Mrs. Adolph, 615 Hampton Pl. 64801
Papp, Mrs. Sandor D., 3343 Pearl 64801
Patterson, Mrs. Donald R., 210 Duquesne 64801
Patterson, Mrs. Grover, 1727 River, Carthage 64836
Pence, Mrs. Wendell, Rt. 4, Box 309, Carthage 64836
Powell, Mrs. Robert, 1818 Galena, Galena, Kan. 66739
Pryor, Mrs. I. J., 2905 Illinois 64801
Roberts, Mrs. Howard H., 650 Jaccard Pl. 64801
Schmidt, Mrs. Herbert J., 820 N. Moffet 64801
Schoeberl, Mrs. C. B., 3111 E. 4th 64801
Schulte, Mrs. Gregory A., 2515 E. 12th 64801
Scorse, Mrs. S. W., 619 W. 2nd 64801
Simons, Mrs. Jess, 2401 Jackson 64801
Smith, Mrs. Roland T., 1444 Crestwood 64801
Smith, Mrs. Russell W., 315 Euclid, Carthage 64836
Straub, Mrs. David L., 811 N. Byers 64801
Upsher, Mrs. Albert E., 69 Canterbury La. 64801
Walker, Mrs. Paul, 1022 N. Sergeant 64801
Wieman, Mrs. Harry K., 636 N. Wall 64801
Willcoxon, Mrs. Robert, 1330 Valle Dr. 64801
Wood, Mrs. George H., 530 E. Highland, Carthage 64836
Wooldridge, Mrs. Bart, 1435 Crestwood 64801
Young, Mrs. C. C., 2518 Markwardt 64801

JEFFERSON COUNTY

Albano, Mrs. Benjamin, Crystal City 63019
Albee, Mrs. Roger, Festus 63028
Bai, Mrs. Sangzin, Festus 63208
Bonifacio, Mrs. Andres, Crystal City 63019
Deles, Mrs. Vicente, Crystal City 63019
Donnell, Mrs. Harold E., 702 N. Main, De Soto 63020
Donnell, Mrs. Hart, Crystal City 63019
Glasgow, Mrs. David S., 113 Mississippi, Crystal City 63019
Judge, Mrs. Thomas, Crystal City 63019
Kang, Mrs. Chang Hueng, 105 Easton, De Soto 63020
Mayfield, Mrs. Logan, Crystal City 63019
Park, Mrs. Duk Jae, 106 N. Mill, Festus 63028
Senn, Mrs. Ernest, Main St., Herculaneum 63048
Sirintrapun, Mrs. Syvee, 123 Mississippi Ave., Crystal City 63019

JOHNSON COUNTY
(Warrensburg 64093)

Cooper, Mrs. R. Lee, Rt. 1
Cooper, Mrs. Robert L., II, 310 Johnson Dr.
Damron, Mrs. O. H., 308 Jones
Folkner, Mrs. Albert L., Rt. 1
Hanna, Mrs. Hugh, Rt. 3
Harkness, Mrs. Harry H., Burkarth Rd.
Hobbs, Mrs. George H., Grandview Dr., Rt. 2
Johnson, Mrs. Charles S., 502 Hurricane Hill
Jones, Mrs. Keith D., 711 South Holden
Lederer, Mrs. Charles M., 617 Clark
Maxson, Mrs. T. Redd, Arilen Acres
Ragland, Mrs. Jerry, Rt. 4

LAFAYETTE-RAY COUNTIES

Boyston, Mrs. Wayne, Odessa 64076
Brady, Mrs. Hugh, Concordia 64020
Cook, Mrs. Thomas B., Richmond 64085
Cope, Mrs. Joseph S., Lexington 64067
Crozier, Mrs. Frank, Sr., Rt. 2, Richmond 64085
Davault, Mrs. George, Richmond 64085
Johnston, Mrs. Esther, Concordia 64020
Kelling, Mrs. Jordan, Waverly 64096

Koppenbrink, Mrs. W. E., Jr., Higginsville 64037
Koppenbrink, Mrs. W. E., Sr., Higginsville 64037
LaHue, Mrs. William, 402 N. 15th, Lexington 64067
Liston, Mrs. Odis, Oak Grove 64075
Martin, Mrs. W. E., Odessa 64076
McFadden, Mrs. Gene, Waverly 64096
Meyer, Mrs. Jerry, 302 Sunset Hill Dr., Concordia 64020
Pavlu, Mrs. Robert R., 14 W. 13th, Carrollton 64633
Riley, Mrs. Charles, Rt. 2, Richmond 64085
Vajaranant, Mrs. Manit, N. 17th, Lexington 64067
Ward, Mrs. Joe W., Lexington 64067

MILLER-MONITEAU-MORGAN

Buehler, Mrs. Carl T., Jr., Eldon 65026
Burke, Mrs. J. P., California 65018
Fulks, Mrs. Richard B., California 65018
Gallagher, Mrs. Lionel M., California 65018
Gunn, Mrs. Jack, Versailles 65084
Hall, Mrs. C. Robert, 2 Country Pl., Versailles 65084
Latham, Mrs. Kenyon, 200 S. High, California 65018
Lyle, Mrs. Ray, Versailles 65084
Shelton, Mrs. E. O., Eldon 65026
Washburn, Mrs. J. L., Versailles 65084

PETTIS COUNTY
(Sedalia 65301)

Block, Mrs. Jerome, Rt. 2
Boger, Mrs. John W., 2803 Skyline Dr.
Braverman, Mrs. Elliot M., Rt. 3, Walnut Hills
Brazos, Mrs. John, Rt. 2
Campbell, Mrs. Albert J., 1500 W. 16th
Cole, Mrs. William R., Rt. 1, Smithton 65350
Edmonds, Mrs. Robert, 2413 S. Stewart
Edwards, Mrs. David R., 1619 S. Moniteau
Eldenburg, Mrs. Donald, Rt. 2
Erickson, Mrs. H. John, Rt. 3, Walnut Hills
Fisher, Mrs. Stanley D., 2200 S. Kentucky
Hopkins, Mrs. Thomas J., 1506 W. Broadway
Hopkins, Mrs. T. S., 524 S. Grand Ave.
Lamy, Mrs. John E., 400½ Dal-Whi-Mo Ct.
Long, Mrs. Frank B., 723 W. 7th
Owens, Mrs. John H., 2616 Plaza
Proctor, Mrs. Donald, 610 W. 3rd
Roberts, Mrs. Paul A., 101 E. Marshall, Sweet Springs 65351
Stauffacher, Mrs. Gordon C., 1313 W. Broadway
Stewart, Mrs. Robert H., 201 Driftwood Dr.
Stockwood, Mrs. Robert C., Rt. 3
Worley, Mrs. C. A., 102 W. Ray, Sweet Springs 65351

ST. CHARLES-LINCOLN COUNTIES
(St. Charles 63301)

Baird, Mrs. Keim L., 16 Warwick Ct.
Cabrera, Mrs. Tom, 10 Marquette, O'Fallon 63366
Canty, Mrs. Eugene, 1824 Sibley
Carpenter, Mrs. James, Rt. 5, Box 43, O'Fallon 63366
Clay, Mrs. Calvin, 808 Oak
Clever, Mrs. Henry, 815 Indian Hills Dr.
Commerford, Mrs. John, 10 Rio Vista
Connelly, Mrs. Michael, 18 Huntleigh Downs, Frontenec 63131
Crider, Mrs. Russell, 1875 S. River Rd.
Damron, Mrs. Edward, 602 N. 5th, Elsberry 63343
DelPizzo, Mrs. Ferdinand, 900 Westminster Dr.
Duncan, Mrs. David, 12911 Cedarledge Ct. 63141
Fleming, Mrs. Robert, 2 Indian Hills Ct.
Goldkamp, Mrs. John, 10 Shawnee
Gore, Mrs. Glenn, 140 Ladue Pines Rd., Creve Coeur 63141
Hammas, Mrs. Roman, 505 Concordia
Hanlon, Mrs. Russell, 2616 Brookridge La.
Hetlage, Mrs. Louis P., 5 Sunset Dr., Troy 63379
Hookerman, Mrs. Bruce, 1207 Oxford Hill Ct., Creve Coeur 63141
Hurd, Mrs. Ronald, 115 S. Cardinal La.
Keller, Mrs. Robert, 712 Parr, Wentzville 63385
Lensenmeyer, Mrs. Charles, 445 Nantucket
Muhm, Mrs. Yale, 548 Riverview La.
Obando, Mrs. Francis, Box C, Troy 63379
Olson, Mrs. Richard, 2901 Headland Dr.
Ordoukhanian, Mrs. Tatool, 1519 Shoemaker Ct., Creve Coeur 63141
Perna, Mrs. Vincent, 14 Rio Vista
Poggemeier, Mrs. William, 23 Shawnee
Rice, Mrs. Ronald, 301 Oriole
Roach, Mrs. Edward, 211 Rio Vista
Roter, Mrs. Alex, 11223 Tureen, St. Louis 63141
Rother, Mrs. Paul, 7 Elmwood Park
Roxas, Mrs. Gene, 20 Anglers Ct., Lake St. Louis 63367
Schneider, Mrs. Thomas, 3716 Runnymede
Shuetz, Mrs. Alfred, 904 Indian Hills Dr.
Smoller, Mrs. Martin, 14 Colonial Hills Pkwy., Creve Coeur 63141
Stergen, Mrs. Nick, 5647 Bermuda, St. Louis 63121
Tejero, Mrs. Jonas, 4 Bellrive Ct.
Thiele, Mrs. Otto, 3100 W. Adams
Towers, Mrs. Orville W., Rt. 1, Box 1
Vafi, Mrs. Houshang, 159 Bellechasse Dr., Chesterfield 63017
Vart, Mrs. Gary Vart, 2620 Park Ave.
Vight, Mrs. James, 405 Spring Valley Ct., Chesterfield 63017
Wipfler, Mrs. Earl, 405 Duckett

ST. LOUIS CITY
(St. Louis)

Bard, Mrs. A. T., 3615 Utah Pl. 63116
Barden, Mrs. Frank W., 41 Beaver Dr. 63141
Bartlett, Mrs. Willard, Sr., 53 Westmoreland Pl. 63108
Benjamin, Mrs. Durand, 7340 Navarre Circle 63123
Bergmann, Mrs. Dwayne, 801 S. Skinker 63105
Bilsky, Mrs. Nathan, 2 Somerset Downs 63124
Bohrer, Mrs. Harry C., 4112 Flora Pl. 63110
Bradley, Mrs. F. R., 7404 Oxford Dr. 63105
Brennan, Mrs. George A., 10546 Hanford 63128
Brennan, Mrs. Robert A., 6030 Highfield 63109
Brown, Mrs. Clyde O., 7419 York Dr. 63105
Brown, Mrs. E. Eugene, 7508 Cromwell Dr. 63105
Brown, Mrs. Seymour, 2169 Bantry La., Chesterfield 63107
Bruns, Mrs. Kenneth, 1 Salem Estates Dr. 63124
Budd, Mrs. John J., Jr., 501 Overhills Dr. 63124
Burroughs, Mrs. W. H., 7327 Pershing 63130
Burst, Mrs. Donald O., 61 Trent Dr. 63124
Cannon, Mrs. Edward M., 20 Briarcliff 63124
Carney, Mrs. Joseph E., 6625 Pernod Ave. 63139
Cherre, Mrs. Charles J., 10 Ridgetop 63117
Ciapciak, Mrs. Stanley J., 30 Log Cabin Dr. 63124
Costa, Mrs. Dominic V., 10 Devondale La. 63131
Crespin, Mrs. Stephen, 10458 Briarbend 63141
Daake, Mrs. John W., 48 Portland Pl. 63108
Dewald, Mrs. Paul A., 60 Conway La. 63124
Diehr, Mrs. Alvin H., Park Tower Apts. 63105
Dorton, Mrs. Robert, 12065 Heatherdane 63131
Dreyer, Mrs. Carl Joseph, 45 Glen Rd. 63119
Dripps, Mrs. Roy C., 7824 Keswick Pl. 63119
Edwards, Mrs. Joseph C., 610 W. Polo Dr. 63105
Eigel, Mrs. Edwin S., 10111 Hilltop Dr. 63128
Feller, Mrs. Harold H., 5834 Bermuda Rd. 63121
Fitzgerald, Mrs. Leo P., 7219 Cornell Ave. 63130
Fitzgerald, Mrs. William T., 6425 Rhodes 63109
Franklin, Mrs. Max S., 7536 Buckingham Dr. 63105
63131
Fries, Mrs. Armand D., 11 W. Geyer La.
Furla, Mrs. Gus John, 57 Broadview Dr. 63105
Gandlmayr, Mrs. Jack M., 13600 Peacock Farm Rd. 63141
Glaser, Mrs. Martin J., 3550 Hawthorne Blvd. 63104
Goldberg, Mrs. Ben, 900 S. Hanley 63105
Green, Mrs. William R., 10311 N. Sunswept 63141
Gresick, Mrs. Robert, 11 Coach-n-Four 63131
Grogan, Mrs. Frank M., 4166 Flora Pl. 63110
Gunn, Mrs. Walter T., 6742 Itaska 63109
Haddock, Mrs. James N., 111 Firwood Dr. 63119
Harkins, Mrs. William B., 7 Kingsbury Pl. 63112
Hassett, Mrs. Henry A., 4440 Lindell 63108
Hawk, Mrs. Bray, 3534 Hawthorne 63104
Haynes, Mrs. Pugh, 8006 Gannon 63130
Henschel, Mrs. Eugene V., 55 Broadview Dr. 63105
Hicks, Mrs. Robert S., 733 Sherwood Dr. 63119
Hogan, Mrs. Patrick C., 9036 Laurel Crest Dr. 63126
Hutchinson, Mrs. William B., 15 Portland Dr. 63131
Jensen, Mrs. Joshua E., 3 Brazillian Ct. 63124
Jones, Mrs. Otey S., 2010 Longfellow Blvd. 63104
Karandjeff, Mrs. A. D., 48 Lake Forest, 63117
Kelly, Mrs. Robert, 5371 Waterman 63112
Kendig, Mrs. John H., 841 Rolfe Dr. 63122
Klein, Mrs. Harry A., 2 Sunswept Dr. 63141
Kluegel, Mrs. William A., 2845 Gravois Ave. 63118
Knight, Mrs. William A., Jr., 12 Briarcliff 63124
Koon, Mrs. Bernard, 207 Crandon Dr. 63105
Krojanker, Mrs. Rolf J., 1060 Purdue 63130
Kronemer, Mrs. Norton S., 703 Westwood Dr., Clayton 63105
Langsdorf, Mrs. Herbert S., 3681 Alberta Ave. 63116
Laux, Mrs. France, 287 Ridge Trail Dr., Chesterfield 63017
Lembeck, Mrs. Joseph A., 4103 Flora Pl. 63110
Lerwick, Mrs. E. R., 40 Portland Pl. 63108
Lewis, Mrs. J. Eugene, Jr., 7129 Kingsbury Ave. 63130
Lohr, Mrs. Curtis H., 300 S. Grand Ave. 63103
Lottes, Mrs. J. Otto, 1028 Winwood Dr. 63124
Macnish, Mrs. James M., 229 Bompart 63119
Mathae, Mrs. George H., 3167 S. Grand Blvd. 63118
Mendonsa, Mrs. Lawrence E., 138 Ridgecrest Dr., Chesterfield 63017
Merenda, Mrs. Sam J., 45 Berry Road Park, 63122
Mowrey, Mrs. William O., 7071 Lindell 63130
Muether, Mrs. R. O., 19 Country Life Acres 63131
Neilson, Mrs. Arthur W., 6349 Alexander Dr. 63105
Neun, Mrs. William F., 5862 Delor 63109
Niesen, Mrs. Frank, 1304 Brynnwood 63124
O'Neal, Mrs. Lawrence W., 9975 Holliston Ct. 63124
Oppenheimer, Mrs. Henry E., 9444 Old Bonhomme Rd. 63132
Orenstein, Mrs. Joseph M., 417 Jackson Ave. N. 63130
Peeler, Mrs. J. O., 10000 Knoll Crest Ct. 63136
Pennington, Mrs. F. Eugene, 27 Log Cabin 63124
Powers, Mrs. Pierce W., 4 Crestwood Dr. 63105
Pyne, Mrs. Herbert, 5329 Mardel 63109
Raybuck, Mrs. Harry Earl, Jr., 22 Rolling Rock Ct. 63124
Ritter, Mrs. Hubert A., 26 Briarcliff 63124
Sanders, Mrs. Robert D., 4214 Flora Pl. 63110
Scheer, Mrs. George E., 53 Berkshire, 63117
Schweiss, Mrs. John F., 1414 Westwind Dr. 63131
Sexton, Mrs. Daniel L., 14 Crestwood Dr. 63105
Shah, Mrs. Anwar, 9810 Log Cabin Ct. 63124
Sherwin, Mrs. Charles S., 3971 Flora Pl. 63110
Smith, Mrs. Benjamin F., 5 Fordyce Manor 63131
Smith, Mrs. Hugh R., 8836 Rock Forest Dr. 63123

Stindel, Mrs. Charles E., 341 Violet La. 63119
Stroud, Mrs. C. Malone, 6232 McPherson 63130
Sudholt, Mrs. Alfred F., 13398 Conway Rd. 63141
Sullivan, Mrs. Clement J., 7740 Mohawk Dr. 63105
Sweet, Mrs. Herbert C., 3 St. James Ct. 63119
Thale, Mrs. Thomas, 351 Meadow Brook, Ballwin 63011
Tjoflat, Mrs. Oliver E., 252 Woodbourne 63105
Tremain, Mrs. Irl G., 4254 Flora Pl. 63110
Vandover, Mrs. John T., 3 Grantwood La. 63123
Vest, Mrs. James C., 2800 Stonington 63131
Virant, Mrs. John A., 119 S. Spoede Rd. 63141
Weinel, Mrs. Francis G., 333 Oakwood Ave. 63119
Weir, Mrs. Don, 625 Sherwood Dr. 63119
Werner, Mrs. William A., 6015 Childress Ave. 63109
Witt, Mrs. Clyde M., 11 Deer Creek Woods 63124
Wittgen, Mrs. Edward M., 8901 Rock Forest Dr. 63123
Young, Mrs. H. McClure, 245 Union Blvd. 63108
Zink, Mrs. Oscar C., 9 The Orchards 63132

ST. LOUIS COUNTY

Alex, Mrs. Morris, 18 Crosswinds 63132
Aronson, Mrs. Abraham, 11 Conway La. 63124
Ayata, Mrs. Sedat, 2 Bon Aire, Olivette 63132
Bagby, Mrs. J. W., 7 Country Life Acres 63131
Bailey, Mrs. Wm. Harold, 9157 E. Milton Ave., Overland 63114
Bergmann, Mrs. John F., 550 Bonhomme Woods 63132
Berndsen, Mrs. Gerard H., 12933 Topping Estates 63131
Berwald, Mrs. David M., 1117 Charter Oak Pkwy., Creve Coeur 63141
Berwald, Mrs. Irvin I., 747 Old Bonhomme Rd. 63130
Bowles, Mrs. G. Robert, 754 Gabriel Ct. 63122
Burnside, Mrs. Charles, 750 N. Taylor, Kirkwood 63122
Cacioppo, Mrs. Joseph E., 609 Claymont Estates Dr., Ballwin 63011
Carlson, Mrs. Arne E., 89 Pebblebrook La. 63141
Catanzaro, Mrs. R. E., 412 Tregaron Pl. 63131
Chinsky, Mrs. Murray, 7200 Colgate Ave. 63130
Costrino, Mrs. Joseph A., 12567 Conway Rd. 63141
Cowdy, Mrs. Edmund V., 220 Woodridge La., Huntleigh Hills 63122
Davidson, Mrs. Morris, 128 Frontenac Forest 63131
Davis, Mrs. Edgar W., 49 Woodcrest Dr. 63124
Deitchman, Mrs. Robert, 1 Ridgegate Dr. 63132
Del Rosario, Mrs. H., 1984 Pick Fair Dr. 63141
Diehr, Mrs. Maurice A., 28 Dromara Rd., Ladue 63124
Dyer, Mrs. Clyde P., Box 2710, Carmel, Calif. 93921
Eidelman, Mrs. Jack, 8001 Watkins Dr. 63105
Eller, Mrs. C. Howe, 1408 Fawnvalley Dr. 63131
Emerson, Mrs. Reynolds L., 618 S. Rock Hill Rd. 63119
Fischer, Mrs. John, 22 Colonial Hills Parkway 63141
Fletes, Mrs. James W., 5601 Lindell Blvd. 63112
Forsman, Mrs. Waldo W., 4128 S. Lindbergh Blvd. 63127
Fox, Mrs. Leon J., 903 S. Warson Rd. 63124
Freiheit, Mrs. Harold, 9270 Rott Rd., Sunset Hills 63127
Fuchs, Mrs. George J., Rt. 2, Barnett 65011
Gall, Mrs. Ira G., 8989 Moydalgan Dr. 63124
Gearhart, Mrs. Wilbur, 14084 Deltona Dr., Chesterfield 63017
Goodman, Mrs. Nathaniel, 9 Scarsdale La. 63117
Goodrich, Mrs. Harold A., 52 S. Rock Hill Rd. 63119
Grundmann, Mrs. Wm. H., 1701 Exuma Dr. 63136
Hickey, Mrs. Glenn M., 510 Lalor Dr., Manchester 63011
Hobbs, Mrs. John E., 25 Woodcrest Dr. 63124
Holscher, Mrs. Edward C., 234 W. Jackson Rd. 63119
Izmirlian, Mrs. Grant, 525 Fairview Ave. 63119
Kamuran, Mrs. Ozgoncu, 322 Laduemont 63141
Kendis, Mrs. Joseph B., 19 Warson Terr. 63124
Kimelman, Mrs. Nathan, 21 Granada Way 63124
King, Mrs. E. E., 2915 Bellerive Dr. 63121
Kingsland, Mrs. R. C., 10 Brookwood Rd. 63131
Klippel, Mrs. Allen, 7112 Wydown Blvd. 63105
Knock, Mrs. Henry, 135 S. Rock Hill Rd., Webster Groves 63119
Kopp, Mrs. Jules H., 23 Arbor Terr. 63122
Korenblat, Mrs. Philip, 11249 Tureen Dr., Creve Coeur 64141
Laird, Mrs. John 3243 Greenmoneh Dr. 63044
Lansche, Mrs. W. Edward, 809 Rampart Dr. 63122
Lord, Mrs. Richard, 8 Mayfair Rd. 63124
Luehrs, Mrs. Robert O., 900 S. Hanley Rd., Apt. 2A 63105
Lund, Mrs. Herluf G., 58 Portland Dr. 63131
Luther, Mrs. George A., 177 Ladue Oaks Ct. 63141
Magidson, Mrs. S. Joseph, 615 Forest Ct. 63105
Magness, Mrs. Guy N., 7727 Blackberry La. 63130
Malles, Mrs. A. Conrad, 68 Woodoaks Trail 63124
Mayer, Mrs. Robert, 614 Spring Meadows Dr., Ballwin 63011
McLean, Mrs. Royal C., 520 W. Jewel 63122
McNalley, Mrs. M., 2100 Raynor Rd. 63122
Meador, Mrs. James R., 9 Bellerive Acres 63121
Meneses, Mrs. Orlando, 1857 Bopp Rd. 63131
Mezera, Mrs. Raymond A., 7345 Whitehaven Dr. 63123
Middleton, Mrs. Jerry N., 24 Foxboro La. 63124
Miles, Mrs. Paul W., 15 Ridge Creek Rd. 63141
Miller, Mrs. Charles, Jr., 206 N. Fillmore 63122
Molden, Mrs. Charles A., 36 Bellerive Acres 63121
Montes, Mrs. Arturo, 11542 Rosary 63138
Moore, Mrs. Harry G., 17 Westmoreland Pl. 63108
Moore, Mrs. William E., 7277 N. Roland Blvd. 63121
Mueller, Mrs. Robert J., 40 Huntleigh Woods 63131
Murphy, Mrs. John, 7245 Princeton 63130
Myers, Mrs. Ivan, 232 Chasselle La. 63141
Nakada, Mrs. James R., 2 Huntleigh Downs 63131
Ott, Mrs. Harold J., 29 Bopp La. 63131
Ottensmeyer, Mrs. Charles, Rt. 1, Box 240, Wild Horse Creek, Chesterfield 63017
Ottolini, Mrs. James L., 12523 Trammel La. 63141
Pennoyer, Mrs. James, 117 Plant Ave. 63119
Phillips, Mrs. Hanford, 215 Graybridge Rd. 63124
Price, Mrs. Robert, 56 High Valley Dr., Chesterfield 63017
Probst, Mrs. Raymond E., 23 Godwin La. 63124
Racadio, Mrs. Sever, 223 Orrick La. 63122
Ragland, Mrs. John, 624 Kehrs Mill Rd., Ballwin 63011
Redington, Mrs. James C., Jr., 1 Tuscany Park 63105
Reiches, Mrs. Aaron, 11 Brazillian Ct. 63124
Reilly, Mrs. Pierce J., 825 S. Hanley Rd. 63105
Richardson, Mrs. Thomas F., 8034 Crescent Dr., Clayton 63105
Roberts, Mrs. Harold K., 434 S. Hanley Rd. 63105
Robertson, Mrs. Frank G., 642 N. Forest 63119
Roblee, Mrs. Melvin A., 5 Kingston Manor 63124
Roufa, Mrs. Joseph, 12390 Montsouris Dr. 63141
Ruhling, Mrs. Rudy, 6 Webster Knolls 63119
Schattyn, Mrs. J. Martyn, 9 Huntleigh Downs 63131
Schlonsky, Mrs. Seymour, 812 Fairways Circle 63141
Schwartz, Mrs. Melvin M., 61 Lake Forest 63117
Schwarz, Mrs. Luis, 8145 University Dr. 63105
Shepherd, Mrs. Charles T., 10 Covington Meadows 63132
Simril, Mrs. Wayne A., 21 Somerset Downs 63124
Sisk, Mrs. James C., 146 Frontenac Forest 63131
Speno, Mrs. Angelo A., 11815 Point Oak 63131
Steiner, Mrs. A. J., 8 Country Aire 63131
Sutter, Mrs. Richard A., 7215 Greenway Ave. 63130
Teiber, Mrs. Fred W., 38 Fair Oaks 63124
Tobias, Mrs. Norman, 700 S. Meramec Ave. 63105
Valach, Mrs. Frank J., 4 Nassau Circle 63141
Vitale, Mrs. Nicholas, 614 Coachlight Lane, Hazelwood 63042
Vollmar, Mrs. C. J., 9756 Old Warson Rd. 63124
Walker, Mrs. Harry, 8142 Amherst Ave. 63130
Walther, Mrs. Roy A., Jr., 7 High Acres Dr. 63132
Walton, Mrs. J. H., 6216 Lindenwood Ct. 63109
Weitman, Mrs. Maximilian, 8326 Delcrest Dr. 63124
Whitener, Mrs. Miles C., 580 Dieman Rd. 63132
Whitener, Mrs. Paul R., 3291 Carlow Pl. 63074
Wittler, Mrs. Harry A., 1919 Korlin Dr. 63131
Wulff, Mrs. George J., 410 N. Newstead Ave. 63108
Yanow, Mrs. Mitchell, 8 Rolling Rock 63124
Yap, Mrs. Mardonio, 53 High Valley Dr., Chesterfield 63017

SALINE COUNTY
(Marshall 65340)

Aiken, Mrs. George A., 50 Ridgecrest Rd.
Blalock, Mrs. Robert W., 526 E. Eastwood
Hall, Mrs. Thomas, Arrow Rock 65320
Haynes, Mrs. R. C., 754 E. Eastwood
Knipschild, Mrs. Bedford F., 505 N. Brunswick
Lawrence, Mrs. John R., Arrow Rock 65320
McBurney, Mrs. C. Alex, 927 Hurt, Slater 65349
McCorkle, Mrs. E. Lee, 791 Eastwood
Raynor, Mrs. Richard C., Rt. 4
Reid, Mrs. James A., 102 E. Rea
Roehrs, Mrs. Marvin Emil, 756 E. Eastwood
Simmons, Mrs. Sterling P., 963 S. Lafayette

SOUTH CENTRAL

Coffee, Mrs. Amos L., Hwy. 60 E., Willow Springs 65793
Cooper, Mrs. C. W., Thayer 65791
Fowler, Mrs. M. L., 1302 W. 3rd, West Plains 65775
Hasek, Mrs. James, 609 Doris Ave., Mountain Grove 65711
Hasek, Mrs. O. Martin, 600 N. Busch, Mountain Grove 65711
Langevin, Mrs. Jack, West Plains 65775
Morgan, Mrs. W. T., 1309 W. 2nd, West Plains 65775
Smith, Mrs. Rollin H., 620 W. Main, West Plains 65775
Walker, Mrs. A. T., Thayer 65791
Wall, Mrs. Joe A., 320 Cherry Ave., Houston 65483
Wiles, Mrs. Jack, 1212 W. Broadway, West Plains 65775
Wood, Mrs. William, West Plains 65775

MEMBERS-AT-LARGE

Allen, Mrs. S. Lloyd, 3809 N.W. 62nd Terr. Kansas City 64151
Bare, Mrs. Edward F., 1211 Main, Tarkio 64491

Barger, Mrs. O. B., Harrisonville 64701
Bass, Mrs. B. J., Salem 65560
Bauman, Mrs. Henry, 929 W. 3rd, Maryville 64468
Campbell, Mrs. James, Loch Forest, Macon 63552
Carlin, Mrs. Albert, 104 W. 7th, Stanberry 64489
Carrington, Mrs. Howard W., 105 Bennett, Lebanon 65536
Comeau, Mrs. Richard, Dexter Convalescent Manor, Dexter 63841
Davis, Mrs. Landis Y., Canton 63435
DeGenova, Mrs. Gerald H., 585 Cedar La., St. Genevieve 63670
Dowell, Mrs. J. Larry, Pattonsburg 64670
Dreyer, Mrs. Philip V., 208 Short St., Huntsville 65259
Dunslee, Mrs. Robert, 145 N. Sunset Dr., Maryville 64468
Eggleston, Mrs. Donald E., 410 N. Rutherford, Macon 63552
Ekern, Mrs. H. Peter, 1415 S. Morris, Mexico 65265
Eklund, Mrs. A. W., 1400 Country Club Dr., Pleasant Hill 64080
Fischer, Mrs. Theodore, P. O. Box 146, Altenburg 63732
Fleming, Mrs. Thomas S., 517 Fort St., Moberly 65270
Froelich, Mrs. R. W., 1345 W. Madison, Lebanon 65536
Hite, Mrs. Dennis, 140 Mockingbird La., Lebanon 65536
Huber, Mrs. L. E., 107 Brinkerhoff, Moberly 65270
Kimball, Mrs. I. W., 6600 Tower Drive N.W., Kansas City 64151
King, Mrs. Richard, 501 S. 2nd, Clinton 64735
Koon, Mrs. Ben, Rt. 3, Bolivar 65613
Love, Mrs. W. S., 527 S. Adams, Nevada 64772
McDermott, Mrs. Alfred E., 1104 Reddick, Perryville 63775
McNeel, Mrs. Lee A., Greenfield 65661
Morgan, Mrs. Troy, 609 E. Clay, Albany 64402
O'Brien, Mrs. Harry F., 408 Harvard Ave., Mexico 65265
Powers, Mrs. John A., 315 N. Pine, Harrison, Ark. 72601
Ramamohana Rao, Mrs. A. R., 505 Allen, Fredericktown 63645
Stricker, Mrs. E. A., 501 Evergreen, St. James 65559
Wetzel, Mrs. Gus, II, 506 S. 8th, Clinton 64735
Wheeler, Mrs. Robert L., 1202 E. South St., Harrisonville 64701

Missouri Voluntary Health Agencies and Organizations

In some instances, patients of MSMA members are eligible to receive assistance from various Voluntary Health Organizations in the state.

Assistance may be in the form of free or subsidized special equipment, rehabilitation training, counseling, specialized care and information and many other areas.

In an effort to assist MSMA members in attaining assistance for their patients, the following list of Voluntary Health Organizations has been compiled. In some cases, a statewide organization is listed, whereas in instances in which an organization is limited to a certain portion of the state, several organizations may be listed under one heading.

This list will be expanded and updated annually.

Arthritis
The Arthritis Foundation
1000 Locust
St. Louis 63101
Hal C. Leichardt, Jr.,
Executive Director
Phone: (314) 421-3550

Arthritis Foundation, Inc.,
Kansas City Chapter
2727 Main
Kansas City 64108
Gordon Waller, Executive Director
Phone: (816) 221-5383

Birth Defects
National Foundation, Inc.,
March of Dimes
209 Adams
Jefferson City 65101
Kay Smith, Director (North)
Dennis Gilmore, Director (South)
Phone: (314) 634-3165

Blind and Sight
Missouri Federation of the Blind
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"Without your help

. . . I simply
would not have
made it through
medical school!"

(The following letter was received on Oct. 1, 1971 from a physician who, as a student, received financial assistance from the Missouri State Medical Association members who have contributed to the Missouri State Medical Foundation. It is printed with his permission.)

Dear Doctor:

"Thank you very much for your thoughtful letter concerning receipt of my final payment on my medical student loan.

"I can well remember the feeling of destitution associated with being a reasonably good student but lacking funds with which to enroll for the next semester in medical school. Having always been, perhaps, more than adequately endowed with pride, it was a lesson in discipline and humility to go seeking financial assistance. However, the effort brought me in contact with some very nice people who really do a lot to keep one's faith in human nature alive.

"I sincerely appreciate the efforts which you and others put into the Missouri State Medical Foundation and all other student loan funds. You should feel a quiet heroism for the assistance you lend to needy students . . . without your help, I simply would not have made it through medical school."

The Missouri State Medical Foundation—MSMF—was created by the Missouri State Medical Association for the express purpose of giving financial assistance to deserving young Missourians who will be tomorrow's doctors.

Send a Check Today to MSMF!

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113 Madison St., Jefferson City, Missouri 65101

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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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MDS

AUGUST, 1974
VOLUME 71, NUMBER 8

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POLYPECTOMY PERFORMED DURING COLONOSCOPY, Daniel Zimmerman, M.D., Stephen B. Lyons, M.D. and Walter Harvey Jacobs, M.D. 487

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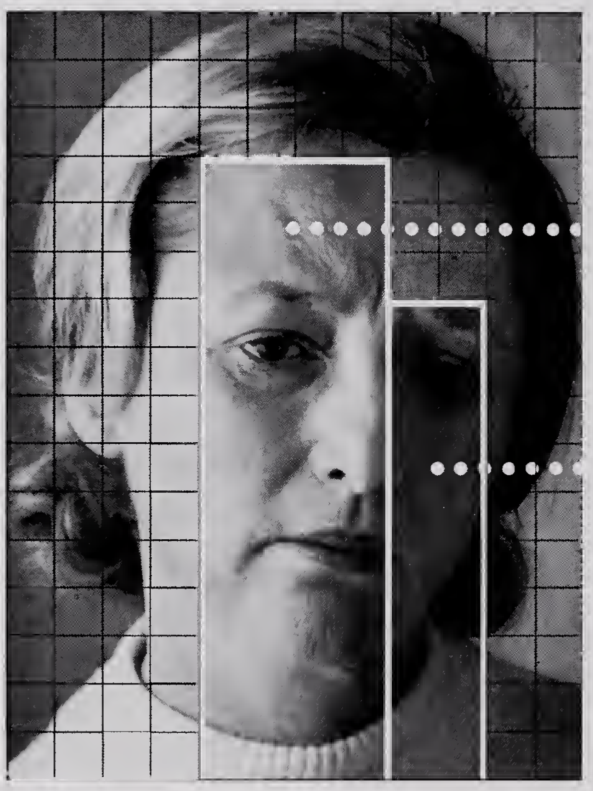
117th MSMA Annual Session
April 17-20, 1975, St. Louis

Both often


Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frec and/or severity of grand mal seizure require increased dosage of standar convulsant medication; abrupt withc may be associated with temporary ir crease in frequency and/or severity seizures. Advise against simultaneo gestion of alcohol and other CNS de sants. Withdrawal symptoms (simila those with barbiturates and alcohol) occurred following abrupt discontin (convulsions, tremor, abdominal an cle cramps, vomiting and sweating). addiction-prone individuals under c

espond to one

According to her major
toms, she is a psychoneu-
patient with severe
ety. But according to the
iption she gives of her
ngs, part of the problem
sound like depression.
is because her problem,
ugh primarily one of ex-
ve anxiety, is often accom-
ed by depressive symptom-
gy. Valium (diazepam)
rovide relief for both—as
cessive anxiety is re-
d, the depressive symp-
associated with it are also
relieved.
here are other advan-
in using Valium for the
gement of psychoneu-
anxiety with secondary
ssive symptoms: the
otherapeutic effect of
m is pronounced and
. This means that im-
ement is usually apparent
patient within a few
ather than in a week or

two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

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ancy, lactation or women of child-
g age, weigh potential benefit
t possible hazard.
utions: If combined with other psy-
pics or anticonvulsants, consider
lly pharmacology of agents em-
; drugs such as phenothiazines,
ics, barbiturates, MAO inhibitors
her antidepressants may potentiate
on. Usual precautions indicated in
ts severely depressed, or with latent
sion, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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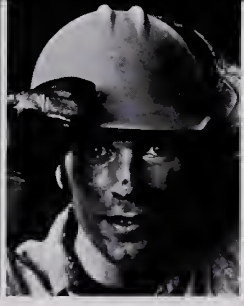
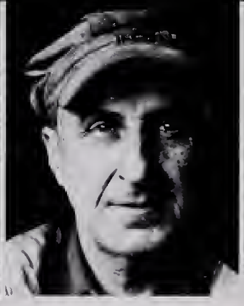
The patient with asthma or allergy

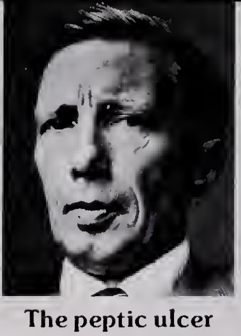


The patient with gastritis



The patient on uricosurics

The patient on anticoagulants



The peptic ulcer patient

The febrile, dehydrated chil

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Missouri Medicine

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Illustrations should be glossy prints or drawings in India ink on white paper. They should not be mounted and name of author and figure number should be penciled lightly on the backs. Legends should appear on a separate sheet. Colored illustrations will be used when suitable if author assumes the actual cost.

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All material other than scientific should be received prior to the first of the month preceding month of publication.

Please give notice of change of address at least one month in advance of the change, giving old and new addresses.

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MSMA
MISSOURI STATE MEDICAL ASSOCIATION

NEWS ROUND-UP

AUGUST, 1974

Missourians are honored by AMA

Two Missourians were among six individuals who received special recognition from the medical profession at the 123rd Annual Convention of the American Medical Association.

Dr. Olsen

Mr. Stark

Robert E. Olsen, M.D., PhD., chairman and professor of biochemistry at St. Louis University Medical Center, won the Goldberger Award for his work in clinical nutrition.

Nathan J. Stark, of Kansas City, received AMA's Layman Award, the highest award the Association can give a non-physican. Mr. Stark, senior vice-president of Hallmark Cards, Inc., was honored for his long service with several organizations devoted to medical care and education.

Ad revenues down

MISSOURI MEDICINE ranked 16th among all state medical journals in page count of national advertising in 1973.

As expected, the larger states led in number of ad pages, according to figures released by the State Medical Journal Advertising Bureau.

A decrease in the amount of advertising sales in state journals has been a major concern of state medical associations the past few years. All state journals were reported to be 20 to 25 per cent behind 1972 advertising revenues. MISSOURI MEDICINE was no exception.

Most of the journal advertising decrease the last few years can be attributed to the fact that 55 additional medical magazines have been established since 1967. These new publications bring the total of medical magazines to 194. The national advertising dollar, therefore, has been divided into several new slices.

It has been pointed out that many of the new magazines are mailed to physicians at no cost and without the physician's request.

MMPAC campaign gains record number of Sustaining Members

Sustaining Memberships in the Missouri Medical Political Action Committee (MMPAC) have reached an all-time high.

In response to a recent membership appeal to all MSMA members, the number of Sustaining Members climbed to 46. The previous high in the category was 33, established in 1973.

To become a Sustaining Member, a member contributes $100 to MMPAC. Half of the funds remain with MMPAC and the other $50 goes to the American Medical Political Action Committee (AMPAC). Of the Sustaining Members, 11 are members of the Woman's Auxiliary.

Along with the Sustaining Members, approximately 90 new MMPAC members responded to the recent mailing. The additional members brought MMPAC closer to its record-setting membership year of 1973. Approximately 1,300 MMPAC members were recorded in 1973 while more than 1,100 have joined thus far in 1974.

Hubert A. Ritter, M.D., of St. Louis, Chairman of MMPAC, expressed the hope that several more physicians will use the Return Envelope provided in the mailing to join MMPAC.

"I'm extremely pleased with the results of the appeal to date," said Dr. Ritter. "However, I know how easy it is to put mail such as this aside for awhile. I feel confident that many more physicians will mail in their memberships."

On a nationwide basis, AMPAC officials have reported that membership is up about 16 per cent over 1973.

Please send MMPAC information to:

Name ______________________

Address ______________________

City ______________ **State** ______________

(A copy of MMPAC report filed with the appropriate supervisory officer is (or will be) available for purchase from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402)

Medical news of interest

State PSRO meeting

Representatives from the five Missouri Area Professional Standards Review Organizations (PSROs) and the Statewide PSRO Support Center held a meeting on PSRO implementation July 19 in Columbia.

The purpose of the meeting was to discuss the approach that each area proposed in its Planning Contract and to share ideas on what assistance may be required of the Support Center.

Last month the Health Care Foundation of Missouri was designated the Statewide Support Center and received a six-month grant of $106,686.

Four area groups in Missouri received PSRO planning grants prior to the end of the Department of Health, Education and Welfare's fiscal year, June 30.

The physician group from the other designated PSRO area in Missouri, located in the Southwestern part of the state, has nearly completed its proposal and is expected to apply for a Planning Contract soon.

The four area PSRO groups and the Planning Contract sums are:

- Central Eastern Missouri Professional Review Organization Committee, St. Louis, $61,000. William C. Lindsley, Jr., Executive Director.
- Mid-Missouri Foundation, Jefferson City, $64,000.
- Northwest Missouri PSRO Foundation, Kansas City, $49,500. Robert E. Watkins, Director.
- Southeast Missouri Foundation for Medical Care, Cape Girardeau, $54,440.

Dr. R. O. Muether dies

Funeral services were held July 16 for Raymond O. Muether, M.D., of St. Louis, a Past President of the Missouri State Medical Association.

Dr. Muether, 68, died July 13.

Dr. Muether served as MSMA President in 1960-61. He was Editor of the association's journal, MISSOURI MEDICINE, from 1949 to 1953. He was also a Past President of the St. Louis Medical Society, serving in 1954-55.

Member is "crack quack"

"Crack Quack" was the headline used on an Associated Press story published recently which was describing one of the MSMA's fine and respected members. However, the AP story from Kansas City explains the headline.

"Dr. Sam Hoeper, a local physician, outquacked 124 other dissonant duplicators to win the Crown Center duck-calling contest.

"The contest, held in the Sportsman's Gallery, completely disrupted shopping in just about all of the 90 specialty stores in the center's retail complex."

The AMA's Committee on Quackery is not expected to investigate the matter.

Insurance seminars set

Paperwork involved in filing insurance claims will be the topic of the fifth annual Seminars on Health Insurance Problems, sponsored by the Missouri Hospital Association and the Health Insurance Council.

The seminars are designed for physician office personnel and hospital personnel who are responsible for filing health insurance claims. Each seminar will pertain only to commercial insurance problems and will not include Blue Shield information.

The registration fee of $6 covers the cost of coffee breaks and lunch. The seminars are scheduled:

October 8	Jefferson City
October 15	St. Louis
October 16	Cape Girardeau
October 24	Kansas City
October 31	Springfield

For a Registration Form, please contact the Missouri Hospital Association, Box 1044, Jefferson City, Mo. 65101.

Recruitment plan available

"Action Plan for Physician Recruitment," a packet of material designed to provide information which may assist small communities in their recruitment programs, is available to MSMA members.

The material has been prepared by the AMA Physicians' Placement Service. For a copy of the packet, please write Placement Service, Missouri State Medical Association, Box 1028, Jefferson City, Mo. 65101.

Large physician increase

Another 16,689 licensed physicians were added to the U.S. medical profession in 1973 — the largest increase in newly licensed physicians in any one year in the history of U.S. medicine.

The 15 per cent increase over the number reported last year is in the 72nd annual report on medical licensure statistics by the American Medical Association's Council on Medical Education.

Of the 16,689 newly licensed physicians, 7,419, or almost one half, were graduates of foreign medical schools, reflecting for the seventh consecutive year a substantial increase in the number of foreign physicians taking state board examinations.

As of Dec. 31, 1973, there were 366,379 physicians in the United States. The total includes 326,933 licensed physicians, a net gain of 12,406 licensed physicians from the same date a year earlier, after physician losses due to deaths, retirements and return of foreign medical graduates to their homelands.

The figures should not be interpreted as meaning that only 326,933 licensed physicians are qualified to take care of patients. Thousands of physicians, working under various medical, educational and government service permits, contribute to patient care.

The Council Reports

Meeting of May 25, 1974

Howard J. McAlhany, M.D., Springfield, Vice-Chairman, called the meeting to order. Those present were Drs. McAlhany; James C. Cope, Columbia; R. Allen Chandler, Kansas City; John I. Matthews, Jefferson City; E. A. Stricker, St. James; Robert A. Slickman, Kansas City; John N. Martin, St. Joseph; Louis P. Hetlage, Troy; Robert E. Bregant, Jefferson City; William D. Bradshaw, Clinton; Andrew McCanse, Kansas City; Claude W. Cooper, Thayer; Eugene T. Hansbrough, Poplar Bluff; William D. Mayer and William C. Allen, Columbia; J. Loren Washburn, Versailles; Hubert A. Ritter, St. Louis; William Stoneman, III, St. Louis; Samuel B. Guze, St. Louis; Herbert R. Domke, Jefferson City; Mrs. George Lytton, Kansas City; Messrs. Sam Wheeler, Kansas City; E. Mark Halvorson, Jefferson City; Allen D. Smith, Kansas City; Hollister S. Smith, St. Louis; Ray McIntyre, Royal O. Cooper, C. C. Swarens, Ron Ellison, Staff.

Dr. Howard McAlhany, Vice-Chairman of the Council, opened the meeting stating regretfully that Dr. Max Frankin, Chairman, was ill and would not be in attendance at his meeting.

On motion, duly seconded, the minutes of the April 7, 974 Council Meeting were approved as distributed.

REPORT OF THE EXECUTIVE SECRETARY

Mr. McIntyre reported on the attendance at the recent 116th MSMA Annual Session, indicating that 670 physicians were in attendance and total registration was 1,054. The scientific sessions were well attended. He read several letters from 50-year-member physicians which indicated that the 50-year pins are definitely appreciated.

Mr. Ron Ellison stated that a meeting will be held on June 8 by the Commission on Interspecialty Medicine, the Commission on Continuing Education and Health Manpower, the Ad Hoc Committee for the 117th Annual Session and the Councilor District Directors on CME. This meeting will be held to discuss and develop guidelines for CME for the state of Missouri and to begin plans for the 117th Annual Session.

Dr. Hansbrough stated that there are many ongoing CME programs in the state and he felt that the Ad Hoc Committee on CME should be given the authority to examine and approve these programs. After brief discussion, it was moved that the Council authorize the Ad Hoc Committee on Continuing Medical Education to begin approving CME programs that are ongoing in this state and to set up a mechanism for approving new programs. Motion was seconded and carried.

Mr. McIntyre said that the AMA Annual Session will be held at the Palmer House in Chicago on June 23-28. Dr. Washburn, senior AMA Delegate, stated that he is calling a caucus for 10:45 on Sunday morning, June 23.

Mr. McIntyre reported that Dr. Joseph White, Columbia, has been recommended to the Board of Trustees of AMA for reelection to the Council on Medical Education.

The Executive Secretary indicated that at least one vacancy and possibly two will occur on the AMPAC Board this coming fall. This Board is appointed by the Board of Trustees of the AMA. It was moved, seconded and approved that the Council go on record as strongly endorsing Dr. Hubert A. Ritter for the AMPAC Board.

Mr. Royal O. Cooper indicated that the Council had approved three new insurance plans—Office Overhead with Eggert-Carroll-Schroeder and Altman-Singleton and Major Medical and Group Term Life with Forrest T. Jones. Staff has been working with these firms and information on the major medical will probably be sent out in July and on the Group Term Life in September and Office Overhead in June.

Mr. McIntyre said that a request had been received from the Missouri Thoracic Society for membership on the Commission on Interspecialty Medicine. The Society has approximately 130 members. All M.D. and D.O. physicians licensed to practice in the state and with an interest in pulmonary diseases are encouraged to join.

It was moved, seconded and carried that the Missouri Thoracic Society be placed on the Commission on Interspecialty Medicine. The MSMA President will appoint a member of this organization to represent them on the Commission as per their request.

COUNCILOR ADVISORS

Dr. McAlhany made the following appointments of Councilors as advisors to the standing MSMA Commissions:

Commission on Medical Economics, Third Party Medicine, and Governmental Relations	Dr. Hetlage
Commission on Continuing Education and Health Manpower	Dr. McCanse
Commission on Interspecialty Medicine	Dr. Hansbrough
Commission on Public Affairs	Dr. Martin
Commission on Medical-Legal Affairs	Dr. McAlhany

REPORTS OF DISTRICT COUNCILORS

District #1—Dr. Martin reported that the Methodist Hospital in St. Joseph has opened its staff to D.O.s. Both hospitals—Methodist and St. Joseph's—are expanding and many of their services are duplicated.

Dr. Martin stated that he still feels that we are not getting the information from the AMA that we should be receiving.

Disricts #2 and #3—Neither Dr. Bach nor Dr. Franklin could be present for this meeting.

District #4—Dr. Hetlage reported that he had held a meeting with the delegates in his district with a quorum present and the following matters were discussed:

There was a discussion of a proposed resolution concerning condensation of policy changes into resolutions. It was the opinion of the group that this was unworkable. However, they did approve the concept and would favor the condensation of Council minutes and Commission reports for publication so that these activities can be more easily understood by the members and by the delegates at the annual convention.

The delegates of the Fourth District went on record as favoring and encouraging the development of malpractice insurance by the state association.

The article in a recent issue of *Medical World News* relative to the AMA Board of Trustees was discussed with considerable concern. Members of the Fourth District feel that the times require leadership of AMA to be representative of and responsive to the general membership and that the conduct of the Board should be such as to be not self-serving or discriminatory. They requested that the AMA

Delegates convey this attitude to the Annual Convention in Chicago in June.

Dr. Hetlage reported that Medicare Bulletin #3 concerning the new "Waiver of Liability" was discussed. On motion of Dr. Hetlage, duly seconded, it was agreed that this matter be studied in further detail by the Commission on Medical Economics.

On motion, duly seconded, it was further agreed that this be referred to the AMA and to have them respond to this in the same way they responded to precertification.

Dr. Hetlage reported that his district agreed that MSMA should expend its educational efforts on legislative programs on which such influence could be effective and not try to change those things which we cannot change. Energy should be directed toward useful and productive endeavors.

Dr. Hetlage stated that his district feels that amalgamation of St. Louis County and St. Louis City into a metropolitan society is necessary for the proper conduct of medical affairs in the area.

Disproportion of private office fees vs. those paid to organized clinics, such as medical schools, by the Welfare Department was discussed at his district meeting. On motion, duly seconded, it was recommend that further study of this matter be made by the Commission on Medical Economics of MSMA. Motion carried.

Dr. Hetlage reported that Dr. Paul Rother, Chairman of the MSMA Planning Committee, was present at the meeting and the group recommended that some of the changes suggested at the meeting be considered by the Planning Committee, such as condensation of minutes and providing more complete information to the House of Delegates on Council and Commission activities. It was further suggested that the Planning Committee recommends to the Committee on Constitution and Bylaws that a hard look be taken at the present Constitution and Bylaws with the idea in mind that they be completely revised to bring them up to date with those of other states.

Dr. Hetlage said that a proposal had been made that the MSMA support those health bills in Congress, otherwise desirable, which would require a means for funding those programs proposed in the bill. That is, if a major program of National Health Care were proposed, means for financing this care also would have to be provided in the bill.

Dr. Hetlage proposed that it might be advisable to consider a change in the Constitution and Bylaws to permit a Vice-Councilor in each district and he made the following motion that "The Council request the standing Committee on Constitution and Bylaws to investigate the manner and means of changing the Constitution and Bylaws to permit the election of a Vice Councilor from each district and to report their findings to the Council at the January Council Meeting." Motion was seconded and carried.

District #5—Dr. Bregant reported that a grant has been approved for the Mid-Missouri PSRO Foundation. The request asked for $50 per hour for peer review physicians' services. However, approval has been given for $35 per hour.

District #6—Dr. Bradshaw indicated that he did not have a report at this time.

District #7—Dr. McCanse stated that the Northwest Missouri PSRO is in the process of applying for a PSRO planning grant.

The Jackson County Medical Society Executive Council recently approved an impartial Medical-Legal Review Plan. This involves both the Jackson County Medical Society, Osteopathic Association and, also, the Kansas City Bar Association and Kansas City Lawyers Association. This Plan has not been approved as yet by all the organizations involved.

District #8—Dr. McAlhany reported that 16 hospitals in Southeast Missouri have withdrawn as member hospitals of the Blue Cross organization. Rather than the patient assigning insurance benefits to the hospital, the patient collect the benefit and pays the hospital.

District #9—Dr. Cooper reported that at a meeting o his delegates, there was quite a clamor for more direction from the AMA and MSMA. They do not feel they are getting enough information and direction. He also stated tha discussion was held regarding the fact that under Medicare a physician has an option of accepting or rejecting assignment. However, under Medicaid no such option exists. On motion of Dr. Cooper, duly seconded, the Council agreed that the concept of assignment option should come along with any new major health insurance plan.

District #10—Dr. Hansbrough indicated that the *Cape Girardeau County Medical Bulletin* is giving him, as District Councilor, a page in the *Bulletin* each month and he is pleased. He suggested that the other county journals in the state might wish to do this also for their Councilors

Dr. Hansbrough expressed his concern regarding Missouri Medicine and indicated that he certainly does no like the possibility of combining the journal with other state journals. He suggested that an editorial be written fo Missouri Medicine soliciting readership in the MSMA Journal and explaining the process that is taking away our advertising. This is to be left to the discretion of the Publications Committee.

REPORT OF THE PRESIDENT

President Cope stated that the House of Delegates had approved a dues increase of $25 beginning in 1975 and asked the Council if some of the new programs should be started immediately, which might mean borrowing money

Dr. Cope said that, unfortunately, the Annual Banquet each year turns out to be a stereotype and it is his feeling that this should be an affair in which people are interested and look forward to attending. Staff looked into the cost of getting a nationally known speaker—for instance, one charges $5,000 and pays his own expenses. Other programs vary considerably in cost.

Dr. Cope reported that he had received a letter from the Governor stating that he had been contacted by the Regional Director of HEW requesting the state to consider the possible development of a planning contract with HEW on the regulatory role Missouri government might perform in health resources planning. A letter was written to the Division of Health, as requested by the Governor, indicating that if it is decided to explore the possibility of a state contract with HEW to begin a planning program, we would like to have an active role in this exploratory activity It is understood that at the present time, there are no funds available for this activity.

Dr. Cope indicated that he has information that the undergraduate M.D. degree program, the Internship and Residency for Family Practice, Medicine, Gynecology and Pediatrics at the University of Missouri have been relegated to a Priority II in the tentative academic plan. This area had previously held a rating of I-A. Dr. Cope wrote a letter to the Board of Curators expressing the Association's concern in this matter. A reply was received indicating lack of funds to be the reason for the lower priority rating. Another letter was written to the Board in answer to this reply.

It was the feeling that the M.D. program and primary care program should be top priority and that it was most appropriate for the Council to communicate with the Board of Curators fully supporting Dr. Cope's letter. Dr. McAlhany stated that with Council approval, such a letter to the Board of Curators will be drafted to be signed by the Chairman of the Council.

REPORT OF THE WOMAN'S AUXILIARY

Mrs. Lytton thanked the Medical Association for its support of the Auxiliary's Annual Convention and 50th anniversary celebration held during the session. She indicated that attendance at the meeting was very good. A booklet has been printed, "50 Years of Service," and it is very interesting to see what went into the Medical Auxiliary beginning 50 years ago. Mrs. Lytton reported that a new approach was tried at the Auxiliary Annual Meeting by having workshops and apparently this worked out very well.

Membership in the MSMA Woman's Auxiliary has declined to the point where a delegate has been lost to the national convention. She asked the physicians to please encourage their wives and other physicians' wives to join and pointed out how much more could be accomplished with a larger membership. The Auxiliary contributed $18,484.70 to AMA-ERF during the past year.

On motion, duly seconded, the Council went on record as favoring an increase in membership in the Woman's Auxiliary and recommends to each county society that it study the possibility of billing for Auxiliary dues jointly with its county society dues.

Dr. Hetlage then brought up a point in President Cope's report regarding whether anticipated new programs should be implemented prior to the dues increase in 1975.

On motion, duly seconded, it was agreed that the Executive Committee go ahead and develop the new programs as expeditiously as possible.

ACTIONS OF THE MSMA HOUSE OF DELEGATES

Dr. McAlhany indicated the disposition of the resolutions passed by the 1974 House of Delegates which are as follows:

Resolution #2—Seat Belt Legislation—Referred to Legislative Committee for further study.

Resolution #3—Hospital Medical Staff Autonomy—To appear in MSMA Journal and councilors to inform constituents.

Resolution #5—MSMA Parliamentary Procedure—Referred to standing Committee on Constitution and Bylaws.

Resolution #8—Discriminatory Fees—Sent to State Insurance Commissioner.

Resolution #13—Hospital Governing Board and Medical Staff Relationships—Publish a summary of the Darling Case in MISSOURI MEDICINE.

Resolution #14—Involvement of Third Parties in the Practice of Medicine—Referred to Commission on Medical Economics.

Resolution #16—Improved Communications with the Membership of MSMA—Executive Committee will implement this.

Resolution #17—Use of Combination of Drugs—Has been sent to AMA and FDA.

Resolution #18—National Health Insurance—Has been sent to AMA.

Resolution #19—Pre-Admission Certification—Letter sent to AMA commending their action on this.

Resolution #20—Physician Involvement in CHP—To be sent to County Medical Societies and request societies to return information to Commission on Medical Economics.

Resolution #21—Cost of Living Council Regulations—Copies sent to Missouri Congressional Delegation.

Resolution #22—Malpractice Insurance—The Council was requested by the House of Delegates to attempt to develop a malpractice program for its members as soon as possible. Dr. McAlhany named the following Ad Hoc Committee on Professional Liability in order to develop and facilitate this program: Drs. Irving Clark, Kansas City, Chairman; Robert L. Willcoxon, Joplin; Jerome I. Simon, St. Louis; R. Allen Chandler, Kansas City; and Howard McAlhany, Springfield. Mr. Cooper indicated that we do have some material to be given to the committee so that they could commence.

Resolution #23—Insurance Coverage for Mental Illness—Referred to Legislative Committee.

Resolution #24—Drunk Drivers—Referred to Legislative Committee.

Resolution #28—Legislation to Teach Human Psysiology in Secondary Schools—Sent to State Department of Education.

Resolution #29—Apply PL 92-603 (Section 249F) to Government Hospitals in Missouri—Sent to HEW, AMA and Social Security Administration.

Resolution #30—Ratify the Equal Rights Amendment—Sent to General Assembly.

Resolution #31—Complete Maternity Coverage—Referred to Legislative Committee.

Resolution #32—Politics in VA Hospitals—Sent to HEW and AMA.

Resolution #33—Coordination of AMA-ERF Fund Recipient with Practicing Physician—Has been forwarded to AMA and will appear in AMA Handbook for Annual Convention.

Resolution #35—Support of House Bill 1254—The MSMA did support this both in the House and Senate.

Resolution #36—Repeal of PSRO Legislation—Sent to Missouri Legislators, President, Missouri Congressional Delegation and Secretary of HEW.

Resolution #38—Constitutional Convention—Referred to Committee on Planning.

Resolution #40—Unified Membership with AMA—Referred to standing Committee on Constitution and Bylaws for write-up of necessary changes in present Constitution and Bylaws. Will be published several times in Journal.

Resolution #41—Opposition to U. S. Senate Bill 2994 and U. S. House Bill 12053—Copies sent to AMA and Missouri Congressional Delegation.

MSMA-SPONSORED TOURS

Mr. Cooper reported that the June 26 trip to Mid-Europe has been sold. Our August trip to Greece has approximately 30 reservations. A trip to Barbados with Marriott World Travel has been planned for November. Mr. Cooper stated that the Travel Committee had received the following proposals for 1975 trips: A Russian trip in October, 1975, a 14-day African trip in January or February 1975 and an Adriatic trip.

REPORT OF THE DEANS

Dr. Stoneman of St. Louis University indicated that he is concerned with Senate Bill 392 which was passed during the last Session of the Legislature. This bill relates to the use of patients or inmates of certain institutions in research and experimentation. He stated that certain parts of the bill were unworkable.

Dr. Domke stated that with some of the responsibilities given to the Division of Health under this bill, it would make the bill impossible to administer with the present staff at the Division of Health.

Dr. Cope stated that MSMA has a Liaison Committee to work with the Executive Branch of Government and if the Council so desired, this committee could be directed to convey to the Governor our feelings that this bill should be vetoed.

Dr. Hetlage moved that the Liaison Committee take our desire in regard to vetoing Senate Bill 392 to the Governor. Motion was seconded and carried.

Dr. Mayer stated he had feelings similar to those expressed by Dr. Stoneman in regard to Senate Bill 392. Dr. Mayer indicated that there is growing interest on the part of graduates from medical schools to enter family practice.

Dr. Guze reported that Washington University had graduated a class of 114. A growing percentage of graduates have elected to take their house staff training in family medicine.

(Continued on page 513)

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*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae.* The usual dosage for Trobicin in adult males is 2 grams intramuscularly[†]; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

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Trobicin (spectinomycin hydrochloride) Intramuscular Injection:
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inocyclitol antibiotic active *in vitro* against trains of *Neisseria gonorrhoeae* (MIC 7.5 mcg/ml). Definitive *in vitro* studies have no cross resistance of *N. gonorrhoeae* n spectinomycin and penicillin.

ations: Acute gonorrheal urethritis roctitis in the male and acute gonorrheal tis and proctitis in the female when due eptible strains of *N. gonorrhoeae.*

raindications: Contraindicated in pa- previously found hypersensitive to spec- cin.

ings: Not indicated for the treatment of s. Antibiotics used to treat gonorrhea ask or delay the symptoms of incubating s. Patients should be carefully examined onthly serological follow-up for at least ths should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae.*

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject **5 ml intramuscularly** for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—**Inject 10 ml intramuscularly** for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
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patients with gonorrheal proctitis and for patients in geographic areas where antibiotic stance is known to be prevalent, initial treatment with 4 grams is preferred.

in Brief

A summary of AMA, medical & health news

American Medical Association / 535 North Dearborn Street / Chicago, Illinois 60610 / Phone (312) 527-1500 / TWX 910-221-0300

If an **NHI program** were enacted, physicians' and dentists' offices would be swamped, costs would be in the billions of dollars and there would be little effect on the life expectancy or general well-being of Americans, according to a report by the Rand Corporation, Santa Monica, Calif. The report, published in the June 13 issue of the *New England Journal of Medicine,* is based on two prototypical national health insurance plans, one providing full coverage and one containing a 25% coinsurance provision. Under the full-coverage plan, the demand for physicians' services would be increased 75%; the demand for hospital services would be increased 5% to 15%; and costs for inpatient and ambulatory services would be increased by $8 billion to $16 billion. Under the coinsurance plan, the demand for physicians' services would rise 30%; the demand for hospital services would increase 0% to 8%; and costs for inpatient and ambulatory services would rise by $3 billion. The report notes that estimates are conservative, are not corrected for general inflation, and are based on the assumption that supply would equal demand.

A **bill designed** to hold the production of physicians and other health professionals at about current levels was proposed by the Administration recently. Charles C. Edwards, M.D., HEW assistant secretary, said it also is intended to change the "mix" of the kinds of professionals produced. "In our judgment," he said, "if the rate of enrollment increases of the past five years were to continue unabated, we are likely to have a surplus of health professionals, especially physicians and nurses," which is undesirable.

AMA will distribute one complimentary copy of the 26th edition of the *American Medical Directory* to each state, county and medical specialty society on the AMA's cooperative list. Additional copies may be purchased for $125 in the U. S., possessions, Canada and Mexico and $140 in all other countries. There will be no free distribution of the *Directory's* supplement, *Directory of Women Physicians in the U. S.*

Medical mail received by physicians has decline 38% since 1959, the Pharmaceutical Manufacturer Association reports. The typical physician gets a average of four pieces of medical mail daily, th PMA said.

Pharmacists would be allowed to substitute ge neric or chemically equivalent drugs for bran name drugs under a bill passed by the Michiga State Senate. The Michigan State Medical Societ has opposed the bill since its introduction in 197 MSMS was successful in getting an amendment at tached to the bill which allows physicians to writ "Dispense as Written" or "DAW" on prescriptior when they want specific brands used. There is n provision in the bill for establishing therapeuti equivalence for substituted drugs. After the Gov ernor signs the bill, it will become effective o January 1, 1975.

A new National Institute on Aging, within th National Institutes of Health, will conduct and sup port biomedical, social and behavioral research an training related to the aging process, disease an special needs of the elderly. Under a new la creating the institute, HEW must conduct scientif studies to measure the biological, medical and psy chological aspects of aging; carry out public info mation and education programs; and prepare comprehensive aging research plan within one yea

Available from AMA: "Action Plan for Physicia Recruitment," an information packet explainin how to recruit and retain M.D.s in small towns an rural communities. Available free from Physician Placement Service, AMA Headquarters . . . Aud cassettes of the six major presentations made the 1974 AMA National Leadership Conferenc $3 each. Write Dept. of Field Services, AMA Hea quarters . . . Audio cassette highlights of the 27 National Conference on Rural Health and the 8 National Conference on the Socioeconomics Health Care. Tapes for each meeting, $3 for AM members and medical societies and $5 for other are available from Radio-TV-Film Dept., AM Headquarters.

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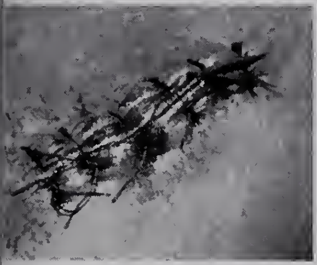

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Notes of interest from Here . . . . and Ther

Five members of the MSMA were honored with plaques in recognition of the services they have rendered to the St. Louis Diabetes Association. They are **Dr. William H. Olmstead** and **Dr. Daniel L. Sexton**, two of the founders of the Association, and **Drs. Paul J. Bettonville, Marvin E. Levin** and **Henry E. Oppenheimer**, who are past-presidents. The occasion was the 25th Anniversary Annual Meeting and Banquet at the Chase Park Plaza Hotel in St. Louis.

Dr. F. T. H'Doubler, Jr., Past-Potentate of Abou Ben Adhem Shrine Temple i Springfield, was elected Imperial 2nd Ceremonial Master at the 100th Imperia Council Session of the Shrine of North America of the international organizatio by voting representatives of 172 Shrine Temples in the United States, Canad Mexico and the Panama Canal Zone.

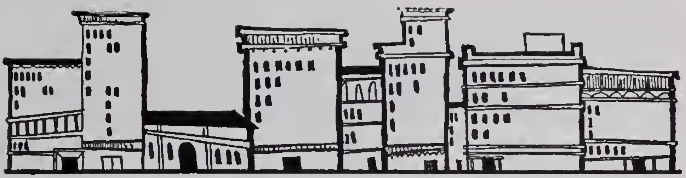
Dr. Christiana V. Hammler of St. James was honored at a party hosted by the Mid-Missouri County Medical Society and the Phelps County Memorial Hospital in recognition of her 60 years of service as a physician. **Dr. E. A. Stricker**, Immediate Past-President of the MSMA, presented a silver tray to Dr. Hammler on behalf of the Mid-Missouri County Medical Society and **Mr. Bill Cowan**, administrator, presented a gift on behalf of the Hospital. Dr. Hammler, a native of Vandsburg, West Prussia, Germany, made St. James her permanent home in 1929 and served that community for 45 years. The celebration was under the direction of **Dr. Barbara E. Russell**, president of the Medical Society.

Dr. Ben Jolly has been elected president of the Mexico Rotary Club. His ter of office began on July 1.—**Dr. Charles N. Mullican** has been elected presiden of the St. Joseph Chapter of the American Diabetes Association.

Dr. Hugh E. Stephenson, Jr., a professor of surgery at the University of Missouri-Columbia School of Medicine, has been elected president of the Missouri Chapter of the American College of Surgeons.—**Dr. Anwar Shah**, St. Louis, was elected president of the Missouri Ophthalmological Society at its spring meeting in Kansas City.

Dr. James C. Sisk, St. Louis, was reelected chairman of the Board of Trustee of the St. Louis Blue Shield Plan at the Annual Meeting of the organization' Voting Board on June 30 in St. Louis. Other officers who were reelected are **D Herbert C. Wiegand**, St. Louis, first vice-chairman; **Dr. Richard K. Danis**, St Louis, vice-chairman; **Mr. E. A. Martin**, Springfield, secretary; and **Mr. Georg P. Meier**, St. Louis, treasurer. **Dr. Doyle C. McCraw**, Bolivar, and **Mr. James L McGregor**, Bonne Terre, were named to serve with the officers as members o the Plan's Executive Committee.

From the Medical Schools



NIVERSITY OF MISSOURI-COLUMBIA

Dr. Joseph M. White, Provost for Health Affairs, vas elected to a second term on the Council of Iedical Education of the American Medical Asso-iation at its June 22-27 meeting in Chicago. *Dr. ernon E. Wilson,* professor in the Department of ommunity Health & Medical Practice, also is in is second term on the Council.

Dr. White currently is vice-chairman of the ten-nember council which is chosen by the House of Delegates of the AMA. He joined the UMC staff ast September. As health affairs provost, he serves s executive director of the Medical Center and oordinates teaching programs in medicine, nursing nd other health areas.

Dr. Robert L. Jackson, professor in the Department of Child Health, was awarded a plaque by he American Diabetes Association in June "in rateful appreciation of his commitment and untiring service on behalf of diabetic youth."

Recognized as a leading authority on diabetes, Dr. Jackson heads the Diabetes Clinic at the UMC Medical Center, one of the major clinical and research centers in the world for children with diabetes. In 1969, he received the Banting Medal, the ADA award named after Sir Frederick G. Banting, codiscoverer of insulin in 1923.

A record number of recent medical school graduates will be in specialty training at the UMC Medical Center and the Columbia Veterans Administration Hospital during the year which began on July 1. Eighty-four new doctors joined the 125 already in training to make a total house staff of 209. In addition, there will be 20 physicians in postdoctoral fellowship programs.

ST. LOUIS UNIVERSITY

Dr. Robert Hanna Felix was the recipient of an honor citation in appreciation of his ten years of dedicated service as dean of the School of Medicine at a testimonial dinner held at the St. Louis Club in Clayton on June 20. Dean Felix retired on June 30 to become program coordinator of the Bi-State Regional Medical Program on July 1. *Mrs. Felix* was the recipient of a silver bowl. The Felix's son-in-law and daughter, *Mr. and Mrs. Richard Hoenigman,* were present for the dinner. Their daughter, Kathy, her husband and two children reside in Berea, Ohio.

Dr. George E. Thoma, vice-president for the Medical Center, was the master of ceremonies for the dinner and spoke for the Medical Center Administration. *Mr. Ben Jackson,* chairman, Board of Trustees Committee on the Medical Center, represented the trustees. Speaking for the University at large was *Rev. Paul C. Reinert,* S.J., University president, *Rev. Edward J. Drummond,* S.J., executive vice-president for the University, and *Rev. Daniel C. O'Connell,* S.J., University president-elect. *Dr. V. L. Willman,* professor and chairman of the Department of Surgery, was the spokesman for the faculty of the School of Medicine. *Rev. George Cadigan,* Episcopal Bishop of the Diocese of Missouri, delivered the invocation. *Mrs. Bonnie Potter,* senior class president, represented the student body.

During his deanship, Dr. Felix established both the departments of community medicine and neurology and recruited 11 new departmental chairman. The full-time faculty has increased 300% and total student enrollment has risen 36%. He was responsible for the writing of the Constitution for the School of Medicine and the granting of a student voice in Medical School affairs on many faculty committees. A massive construction and renovation program at the Medical Center began while he was dean.

Dr. Robert E. Olson, professor and chairman of

Dr. Robert H. Felix, retiring dean, accepts plaque of appreciation from Rev. Paul C. Reinert, S.J., University president. Dr. George E. Thoma, vice-president of the University's Medical Center, is at right.

the Edward A. Doisy Department of Biochemistry, was the recipient of the Joseph Goldberger Award in Clinical Nutrition at the annual American Medical Association meeting in Chicago on June 22-27. Dr. Olson was honored for his research into how fats are transported and metabolized in the body and for his studies of the fat-soluble vitamins. He is considered one of the premier nutrition research scientists. The award was presented by the AMA board of trustees. Dr. Olson received a plaque and a $1,000 award.

WASHINGTON UNIVERSITY

The National Institutes of Health has granted $267,427 to a School of Medicine investigator to research the effects of insulin on fat stored in cells.

Leonard Jarett, M.D., professor of pathology and medicine, will use the grant to continue research begun in 1967. The 37-year-old physician, director of Barnes Hospital's Diagnostic Laboratories, said, "The long-range goals of the study are to add to our knowledge of diabetes and obesity and to give insight into some of the hormonal control mechanisms that are involved."

Dr. Jarett was one of the 25 young scientists in the United States and Canada honored as a Markle Scholar in Academic Medicine in 1967. He received the B.A. degree with honors from Rice Institute in 1958 and the M.D. degree, cum laude, from Washington University School of Medicine in 1962.

Eli Robins, M.D., Wallace Renard Professor of Psychiatry and head of the department, has received the Gold Medal from the Society of Biological Psychiatry. The award was presented at the Society's 29th Annual Meeting in Boston on June 10. Dr. Robins was the ninth recipient of the award since its inception in 1966. His citation was "for significant contemporary contributions to the advancement and extension of knowledge in biological psychiatry."

Dr. Robins has been at Washington University since 1949 when he was appointed a U. S. Public Health Fellow in Pharmacology and Neuropsychiatry. He became an instructor in neuropsychiatry in 1951, assistant professor of psychiatry in 1953, associate professor in 1956, and professor in 1958.

Donald H. Finger, M.D., succeeded *James A. Wood,* M.D., as president of the Washington University Medical Center Alumni Association on July 1.

George B. Rader, M.D., is now president-elect and *W. Edward Lansche,* M.D., is vice-president of the 6,000-member organization. *Duane C. Hellam,* M.D., is secretary-treasurer.

Continuing Education Coming Events

Sept. 4	**Postgraduate Seminar: Treatment of Chronic Renal Disease** The Ed Bixby Institute for Postgraduate Medical Education Research Hospital and Medical Center, Kansas City
Sept. 14	**Annual Seminar: Industrial Injuries of the Hand** Hand Section of Plastic Surgery, Washington U. and Milliken Hand Rehabilitation Center Clopton Auditorium, Barnes and Allied Hospitals, St. Louis
Sept. 27-28	**The Long Weekend: Gastrointestinal Disease and Rheumatology** MU-KC School of Medicine and Division for Continuing Education, Kansas City Southwest Clinical Society and the Academy of Health Professions Alameda Plaza Hotel, Kansas City
Nov. 13-15	**Postgraduate Course: Advances in Clinical Pediatrics** Danciger Institute for Health Sciences; Depts. of Pediatrics of St. Luke's Hospital, Menorah Medical Center and The Children's Mercy Hospital; Missouri Chapter of the American Academy of Pediatrics, the Kansas City Academy of Family Physicians and the MU-KC School of Medicine Children's Mercy Hospital, Kansas City

Welcome to Portland, Oregon for the 28th Clinical Convention

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Opinion & Dialogue

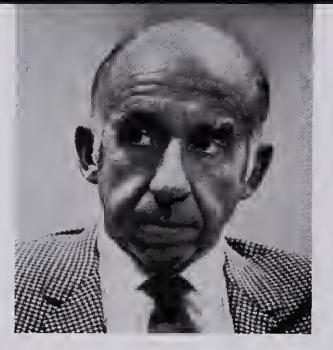
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoo on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

He a Source of Information?

Yes, with certain reservations. ie average sales representative s a great fund of information out the drug products he is re- onsible for. He is usually able to iswer most questions fully and telligently. He can also supply prints of articles that contain a eat deal of information. Here, o, I exercise some caution. I usu- y accept most of the statements id opinions that I find in the ipers and studies which come om the larger teaching facilities. goes without saying that a physi- an should also rely on other urces for his information on iarmacology.

aining of Sales Representatives

Ideally, a candidate for the osition as a sales representative a pharmaceutical company iould be a graduate pharmacist no has a questioning mind. I don't ink this is possible in every case, id so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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ipacity they are indeed useful; articularly in the fact that they sseminate broadly based educa- onal material and serve not just "pushers" of their drugs.

ie Other Side of the Coin

Obviously, the pharmaceuti- il companies are not producing all is material as a labor of love— ey are in the business of selling oducts for profit. In this regard e ambitious and improperly moti- ited sales representative can ert a negative influence on the acticing physician, both by pre- nting a one-sided picture of his oduct, and by encouraging the actitioner to depend too heavily drugs for his total therapy. In iese ways, the salesman has often istorted objective reality and ndermined his potential role as an lucator.

he Industry Responsibility

Since the detail man must be information resource as well as representative of his particular harmaceutical company, he iould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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DANIEL ZIMMERMAN, M.D., STEPHEN B. LYONS, M.D.
and WALTER HARVEY JACOBS, M.D., *Kansas City*

Polypectomy Performed During Colonoscopy

During the previous year, 24 colonoscopic examinations have been performed. They were associated with the intention of removing polypoid growths of the colon (as opposed to simple diagnostic colonoscopy). This report presents an analysis of the technique of the procedure, the success rate, the finding of unsuspected lesions and the complications as well as the saving of suffering and cost to the patient.

Methods

Patients are instructed to remain on a liquid diet for three days prior to the colonoscopy. Most patients are admitted to the hospital the day before the procedure and routine studies are obtained. Routine studies include a complete blood count, urinalysis, SMA-12, EKG (if over 35 years of age), prothrombin time, platelet count and partial thromboplastin test.

The night before the procedure, a 1-qt-tap-water enema is administered. Also, the patient ingests four bisacodyl (Dulcolax) tablets. Another cleansing enema is given the morning of the procedure. Then, the patient receives 100 mg of phenobarbital, 75 mg to 100 mg of meperidine and 30 mg of propantheline bromide, intramuscularly. If the patient is wide-awake, additional doses of meperidine and diazepam are subsequently given intravenously to maintain a state of somnolence.

The colonoscope is introduced with the patient lying in the left lateral position. The procedure is done in the gastroenterology suite of the outpatient department instead of the Operating Room. Fluoroscopic guidance of the insertion of the colonoscope is not utilized.

The Olympus colonoscope has been used almost exclusively in this procedure. For lesions in the descending colon or more distal, the 110 cm scope is used. For lesions in the proximal colon, i.e., proximal to the splenic flexure, the 180 cm scope is used. A trained, experienced gastroenterologist inserts the colonoscope rectally. He manipulates the controllable tip, using the distal controlling levers and, following the lumen, proceeds up the colon. Then he finds the polyp and slips the snare about the lesion, pulling it tight near the base. After approximately one minute, a one second current from the Cameron-Miller cautery unit is applied and the polyp drops off. Subsequently, the polyp or polyps are recovered after expulsion of an administered 2 qt tap-water enema. (In the early days of the procedure, the presence of a surgeon as

In this report of 16 successful transcolonoscopic polypectomies of 24 attempted, the authors analyze the technique of the procedure, the success rate, the finding of unsuspected lesions and the complications. They emphasize the savings and cost to the patient. Dr. Zimmerman is a former Resident in Medicine and Dr. Lyons is a Resident in Medicine at Menorah Medical Center. Dr. Jacobs is Head of the Section of Gastroenterology, Department of Medicine, Menorah Medical Center and Clinical Associate Professor of Medicine at the University of Missouri-Kansas City and Kansas University Medical Center, Kansas City, Kan.

TABLE 1
SUCCESSFUL POLYPECTOMIES

Patient	*Age*	*Sex*	*Location of Polyp (From Anus)*	*Type of Polyp*	*Hospital Stay (Days)*	*Pathology*	*Complications*	*Surgery*
#1	60	F	60 cm (descending colon)	Stalk	2	Adenomatous polyp, 2.5 cm	None	None
#2	47	M	40 cm (upper sigmoid)	Stalk	2	Adenomatous polyp, 3.0 cm	None	None
#3	48	F	80 cm (descending colon)	Stalk	2	Adenomatous polyp with atypia, 2.0 cm	None	None
#4	53	F	18 cm (sigmoid)	Sessile	Outpatient	Villous adenoma, 2.5 cm	None	None
#5	35	M	40 cm (sigmoid)	Stalk	Outpatient	Adenomatous polyp, 0.5 cm	None	None
#6	44	M	15 cm (sigmoid)	Stalk	2	Adenomatous polyp, 2.5 cm with cancer in situ	None	None
			25 cm (sigmoid)	Stalk		Adenomatous polyp, 1.0 cm		
#7	62	F	18 cm (sigmoid)	Stalk	4	Adenomatous polyp	None	None
			16 cm	Stalk		Adenomatous polyp		
#8	60	M	40 cm (sigmoid)	Sessile	12	Infiltrating carcinoma	Brief bleeding, no drop in hemoglobin	Area resected, no residual
#9	66	F	40 cm (sigmoid)	Stalk	2	Adenomatous polyp	None	None
#10	70	M	35 cm (sigmoid)	Stalk	6	Adenomatous polyp	None	None
#11	55	F	60 cm (descending colon)	Stalk	2	Adenomatous polyp	None	None
			40 cm (sigmoid)	Stalk				
#12	64	M	50 cm (sigmoid)	Stalk	2	Adenomatous polyp, 2.5 cm	None	None
#13	80	F	40 cm (sigmoid)	Stalk	3	Adenomatous polyp, 2.0 cm	None	None
#14	56	F	80 cm (descending colon)	Stalk	2	Polyps lost	None	None
			60 cm (descending colon)	Stalk				
#15	62	F	120 cm (ascending colon)	Sessile	2	Adenomatous polyp, 2.5 cm	None	None
#16	65	M	60 cm (descending colon)	Sessile	2	Adenomatous polyp with carcinoma in situ	None	None

TABLE 2
COLONOSCOPY REVEALED OBVIOUS SURGICAL SITUATIONS
(Snaring Not Attempted)

Patient	*Age*	*Sex*	*Location of Polyp (From Anus)*	*Hospital Stay Type of Polyp*	*(Days)*	*Pathology*	*Complications*	*Surgery*
#17	64	M	Carcinoma in ascending colon	Sessile	14	Infiltrating carcinoma, 4.0 cm and villous adenoma	Uneventful colonoscopy revealed cancer missed on x-ray	Right hemicolectomy (uneventful)
#18	60	F	Villous adenoma in ascending colon, 140 cm	Sessile	14	Villous adenoma 3.0 cm and infiltrating carcinoma	Uneventful colonoscopy	Uneventful right hemicolectomy
#19	51	F	40 cm (sigmoid)	Extramucosal lesion	10	Lipoma, 4.0 cm	Uneventful	Sigmoid resection
#20	60	F	40 cm (descending colon)	Sessile	10	Infiltrating carcinoma, 2.0 cm	Too large and too broad-base to snare	Sigmoid resection

TABLE 3

COLONOSCOPY AND SNARING ATTEMPTED UNSUCCESSFULLY

Patient	*Age*	*Sex*	*Location of Polyp (From Anus)*	*Type of Polyp*	*Hospital Stay (Days)*	*Pathology*	*Complications*	*Surgery*
#21	51	F	50 cm (sigmoid)	Sessile	10	Villous adenoma, 3.0 cm	Unable to get snare around polyp	Sleeve resection of sigmoid
#22	51	F	130 cm (transverse colon)	Sessile	2		Unable to reach polyp with 110 cm scope (180 cm scope broke that day)	Will try to snare after large scope repaired
#23	59	F	60 cm (descending colon)	Sessile	14	Infiltrating carcinoma, 2.0 cm	Perforation of sigmoid colon during insertion of colonoscope	Repair of perforation Sigmoid resection of carcinoma Uncomplicated course
#24	63	F	120 cm (distal transverse colon) just proximal to the splenic flexure	Stalk	2	Multiple biopsies—benign adenomatous polyp, 2.0 cm	Unable to get snare about polyp	Deferred

an assistant and for safety purposes was utilized. This is no longer done.)

Presently, we are using a homemade snare made of Teflon tubing and braided steel wire. It is our feeling that it works quite well and probably better and is definitely much less expensive than the commercially available snares.

Results

As shown in Table 1, both sessile and pedunculated polyps have been removed. Furthermore, we have been successful in removing polyps as far from the anus as the ascending colon. However, most of our polypectomies were for lesions in the descending and sigmoid colon which are above the reach of the sigmoidoscope.

Table 2 reveals that colonoscopy demonstrated that four of the patients had lesions requiring surgical therapy. In Case #17, the x-ray indicated a polypoid lesion in the ascending colon. However, colonoscopy detected three lesions which were a large, saucer-shaped carcinoma; a tiny satellite carcinoma; and a large, broad-based villous adenoma (the latter was the lesion seen on the x-ray). Successful right hemicolectomy was accomplished.

When we performed colonoscopy on Patient #18, we saw the enormous broad base to the polyp and felt that attempted polypectomy carried too great a hazard. The colonoscope was removed without attempted further insertion. Had we completed the procedure, we would have observed another carcinoma which was missed on barium enema examination but detected and removed at surgery, together with the large villous adenoma that the x-ray revealed and that we saw with the colonoscope. The barium enema test on Patient #19 revealed a filling defect in the proximal sigmoid colon. Endoscopy revealed this to be a very large, extramucosal lesion; surgical excision of a huge lipoma was accomplished. Case #20, with a large, sessile polyp shown on x-ray, showed a very broad base, almost as wide as tall, at colonoscopy. We made a half-hearted attempt to snare it. Then, we wisely decided that surgical excision would be safer. The lesion was proven histologically to be an infiltrating carcinoma.

Table 3 identifies our four failures. Patient #21 was a woman who had had a previous hysterectomy. We were unable to center the tip of the polyp in our field of vision and could not slip the snare over the lesion. The newest model of Olympus colonoscope, soon to be delivered to us and to others in this country, has an additional distal elevator to raise and lower the snare separately from the colonoscope tip. With this instrument, we might have been able to remove this polyp. (The surgeon, too, had a difficult time in mobilizing the colon bound down by adhesions in this case.) In Case #24, a polyp was present just proximal to the splenic flexure. The fold on the mesenteric side kept getting in the way, and we also were unable to slip the snare over this polyp. The elevator would have helped here, also. Case #22 points out the fragility of these instruments and the cost of properly equipping an endoscopic laboratory. In this situation, we inserted the 180 cm colonoscope. On the first manipulation, a control wire snapped. This allowed us control of the tip in only three of the four possible directions. We removed the scope, but were unable to reach the polyp in the transverse colon with the 110 cm scope. In the near future, we will have a new 180 cm scope (cost, approximately $4,000) plus our old 180 cm scope and the 110 cm scope as reserve instruments.

Case #23 was our only major complication in the series. The colonoscope was inserted in the usual manner with the patient in the left lateral decubitus position. The tip of the scope was identified immediately as lying free in the peritoneal cavity. The patient was taken to surgery one hour later; the perforation was repaired and the polyp was excised. This polyp showed infiltrating carcinoma, so surgery would have been recommended eventually. The patient's postoperative course was uneventful.

Incidentally, this was the first perforation ever experienced by the senior author, who has been involved in approximately 100 colonoscopies and 2,000 upper gastrointestinal endoscopies. Our only other complication of significance was the recognition of an arterial "spurter" at the base of the polyp in Patient #8. Bleeding stopped spontaneously without a drop in the patient's hemoglobin. At subsequent resectional surgery (as the lesion was an infiltrating carcinoma), there was no evidence of residual tumor. However, two thrombosed blood vessels were noted at the former polyp's base.

Also, we had a complication not mentioned in the literature previously. Patient #14 had two polyps successfully removed at 80 cm and 60 cm from the anus. These were not immediately retrieved by enema. The patient returned to the floor. On having her next bowel movement, rather than use the bed pan, she expelled the polyps into the toilet and they were flushed down.

ADVANTAGES OF THE PROCEDURE

Certain advantages inherent to transcolonoscopic polypectomy are obvious. The patient is spared a laparotomy and the attendant increased expense of additional days of hospitalization, plus loss of work and subsequent income. In all cases wherein the patient was admitted to the hospital for elective successful polypectomy, the related hospital stay was no more than two to three days. This is in contrast to those patients who undergo laparotomy with either colectomy or colotomy for polyp removal and who are hospitalized for ten to 14 days at a daily hospital rate of more than $60, not including the cost of anesthesia, operating room, recovery room, antibiotics, intravenous feedings and other needs. The savings in time and expense are easily recognized. Also, in the patient with various increased risk factors, i.e., chronic obstructive pulmonary disease, advanced age, heart diseases, the lack of the need for general anesthesia is indeed an inestimable advance in hospital service.

Physician's fees are lower than those cited by Bloom.[1] Moreover, we agree with Friedman[2] that improved techniques should be associated with reduced fees charged to patients. In other words, costs to patients are significantly lower than those charged for laparotomy associated with either a colectomy or colotomy to accomplish a polypectomy.

DISCUSSION

Cynics may say complications are too great a risk in this relatively new procedure. Yet, if the worst happens and a perforation occurs, the patient would then have to undergo an abdominal surgical procedure, which, prior to the time of colonoscopy, would have been required anyway. Bleeding complications have been handled by transfusions.[3] To date, the literature contains no reports of bleeding having been a primary indication for laparotomy.

Certain cautions have been sounded. J. Panesh,[4] in a personal communication to the senior author, has warned that submucosal tumors, particularly lipomas, should be biopsied with caution as they may bleed uncontrollably. S. Wirtschafter,[5] in a personal communication to the senior author, has reported knowledge of ten or more perforations having occurred during colonoscopy in the Southern California area alone. Meyers[6] has reported a death following colonoscopy. On a more optimistic note, however, B. Shatz,[7] in a personal communication, has reported doing simple uncomplicated polypectomies on an outpatient basis in the St. Louis area and Wolff and Shinya[3] recently reported 303 successful polypectomies.

SUMMARY

We have reported 16 successful attempts at transcolonoscopic polypectomies which were performed at Menorah Medical Center during the previous year. Complications have been reported, as have

(Continued on page 497)

CHARLES B. ANDERSON, M.D., DOUGLAS G. NUELLE, M.D.
and* CHARLES L. ROPER, M.D., *St. Louis

Biopsy of Scalene Lymph Nodes

The biopsy of scalene lymph nodes was first described by Daniels[1] in 1949 as a method for the diagnosis of certain intrathoracic diseases. Since that time, the procedure has been used increasingy to diagnose and stage both intrathoracic[2, 3] and extrathoracic[4-6] diseases. Most physicians agree that under most circumstances, biopsy of palpable scalene lymph nodes provides valuable information. Controversy exists, however, with regard to the biopsy of nonpalpable scalene lymph nodes.[7] Routine scalene lymph node biopsy for staging and diagnosis of carcinoma of the lung has been proposed. Others have advocated its routine use for staging carcinoma of the prostate,[4] stomach,[5] cervix[8] and pancreas.[6] This report critically reviews 150 scalene node biopsies performed on a resident surgical service at the Max C. Starkloff Memorial Hospital (City Hospital) in St. Louis.

Material and Methods

The pathologic records of all scalene nodal biopsies were reviewed for the period April 1, 1967 through Dec. 31, 1972. During that time, 155 consecutive specimens of scalene or supraclavicular lymph nodes were submitted for histologic examination. Medical records of 144 of these patients were available for review. Six had bilateral procedures (a total of 150 biopsies). The patients' ages ranged from one year to 87 years with a mean age of 56 years. One hundred and seven were men and 43 were women. Seventy-nine biopsies were made on the right side and 71 on the left side. Local anesthesia was employed in 141 cases and general anesthesia in nine. In 78 instances, lymph nodes were palpable prior to biopsy.

A routine scalene nodal dissection was performed, as described by Daniels.[1] If grossly pathologic tissue was encountered superficially during the dissection and the procedure was terminated at that point, the specimen was classified as "supraclavicular" rather than as a "scalene" nodal biopsy. By this criterion, there were 34 supraclavicular and 116 scalene nodal dissections. However, this distinction was not considered in analyzing the results.

The selection of patients for scalene nodal biopsy depended on multiple factors. Screening of cases by the medical services and individual preference of the surgeon in charge influenced the choice of candidates for biopsy. It is emphasized that the results reported pertain to a selected group of patients and that routine biopsies were not performed. During the time of this retrospective study, mediastinoscopy was employed only sporadically and had not become a routinely or frequently employed procedure in this institution.

Results

Clinical Diagnosis

The preoperative diagnoses are tabulated in Table 1. Carcinoma of the lung was the most frequent diagnosis prior to scalene node biopsy; other diagnoses in order of decreasing frequency were other malignancies, tuberculosis, sarcoidosis and a variety of miscellaneous diagnoses. Primary pulmonary disease was suspected in 113 patients. The final diagnosis for each case is listed in Table 1. Carcinoma of the lung was diagnosed in 75 patients. Extrapulmonary carcinoma existed in 18, tuberculosis in 12, sarcoidosis in 3 and a variety of diseases in the remainder.

Pathologic Findings

The pathologic findings are shown in Table 2. Various malignancies accounted for 30% of the pathologic diagnoses; normal nodal cytology was present in 29% of biopsies. Reactive hyperplasia existed in 16% of specimens, granulomatous disease

Since 1949, the biopsy of scalene lymph nodes has been used increasingly as the procedure for diagnosing and staging both intrathoracic and extrathoracic diseases. The authors report the results of 150 scalene node biopsies performed on a resident surgical service at the Max C. Starkloff Memorial Hospital (City Hospital) in St. Louis. Dr. Anderson is Assistant Professor of Surgery, Dr. Nuelle is Assistant in Surgery (Intern) and Dr. Roper is Associate Professor of Clinical Surgery (Cardiothoracic Surgery) at Washington University School of Medicine.

TABLE 1

Clinical Diagnosis	*Preoperative*	*Final*
Carcinoma, lung	91	75*
Carcinoma		
GI tract	5	4
female genital tract	3	3
breast	2	2
pancreas	0	2
kidney	1	1
head and neck	2	1
prostate	1	5
thyroid	1	0
site undetermined	3	0
Lymphoma	6	1
Leukemia	1	2
Tuberculosis	7	12
Sarcoidosis	7	3
Granulomatous disease	1	1
Bacterial pneumonia	1	3
Pulmonary infiltrates	2	0
Pleural effusion	1	1
Pulmonary embolism	0	2
Emphysema	0	2
Pneumoconiosis	0	2
Cervical adenopathy	5	0
Cervical lymphadenitis with abscess	2	3
Lipoma	1	1
Exfoliative dermatitis	1	1
None made	1	2
Miscellaneous	5†	12‡
Unknown	0	9

* 67 cases proven and eight cases suspected on clinical grounds.

† Edema of left arm, lymphedema of lower extremities, hilar mass, supraclavicular mass, perihilar adenopathy.

‡ Actinomycosis, aspergillosis, chronic staphylococcus infections, lymphopathia venereum, lobectomy for tuberculosis, asthma, fever of unknown origin, fractured humerus, aortic aneurysm, Laennec's cirrhosis, neurilemoma, thymoma.

in 9%. Eight per cent of the specimens contained no lymph nodes. Three specimens contained nerve tissue.

Clinical and Pathologic Correlation

Table 3. A positive diagnosis was one that had clinically significant histologic findings, i.e., reactive hyperplasia, anthracosis and nerve tissue without neurologic deficit were not considered to be significant diagnoses. Forty-four percent of all biopsies yielded a definitive pathologic diagnosis. Thirty percent of the histologic diagnoses confirmed the final diagnosis, and 1.5% differed from the final diagnosis. Of 78 patients with palpable nodes, 70% of the biopsies yielded a pathologic diagnosis, 14% showed reactive hyperplasia, 10% showed normal nodes and 2.5% showed no nodes in the specimen However, of the 72 patients without palpable node biopsied preoperatively, only 15.5% yielded a pathologic diagnosis; 49% had normal nodes, 18% showe reactive hyperplasia and 14% had no nodes in th specimen.

TABLE 2

Pathologic Findings	*Number of Case*
Adenocarcinoma	15
Epidermoid carcinoma	14
Undifferentiated carcinoma	12
Oat cell carcinoma	1
Transitional cell carcinoma	1
Metastatic papillary carcinoma of thyroid	1
Lymphoma	3
Noncaseating granuloma	9
Caseating granuloma	4
Nerve trunks	3
Anthracosis	2
Acute inflammation	1
Chronic inflammation	1
Aberrant thyroid	1
Neurilemoma	1
Lipoma	1
Normal nodes	43
Reactive hyperplasia	24
No nodes in specimen	12
Specimen not received	1
Total	150

Table 4. Among 66 patients having a diagnostically positive biopsy, two thirds had a neoplasm an one third had benign disease. The ratio of neoplasm to benign disease was 2:1 whether or not th lymph nodes were palpable preoperatively.

Table 5. The frequency with which the biops confirmed the initial diagnosis was compatible wit the initial diagnosis or changed the initial diagnosi which was tabulated to permit evaluation of th predictive worth of the biopsy. Fifty-seven percen of the 78 patients with preoperatively palpabl lymph nodes had a tissue diagnosis that confirme or was compatible with the preoperative diagnosis Twelve percent of these biopsies yielded tissu diagnoses which *altered* the preoperative diagnosis When nodes were not palpable, however, only 17 yielded a tissue diagnosis which confirmed or wa compatible with the preoperative diagnosis. In onl one case with nonpalpable nodes (1.5%) did th nodal biopsy yield a definitive diagnosis whic differed from the preoperative diagnosis! This patient was a 71-year-old man who was thought t have carcinoma of the lung preoperatively, bu

TABLE 3

BIOPSIES OF SCALENE LYMPH NODES—CLINICAL PATHOLOGIC CORRELATION

	Preoperatively Palpable Nodes		
Results of Biopsy	Yes	No	*Total*
Confirmed final diagnosis	37 (48%)	7 (10%)	44 (30%)
Compatible with final diagnosis	16 (20%)	4 (5.5%)	20 (13%)
Differed from final diagnosis	2 (2.5%)	0 (0%)	2 (1.5%)
Normal nodes	8 (10%)	35 (49%)	43 (29%)
Reactive hyperplasia	11 (14%)	13 (18%)	24 (16%)
No nodes in specimen	2 (2.5%)	10 (14%)	12 (8%)
Other diagnoses	2 (2.5%)	3 (4%)	5 (3%)
Total cases	78 (100%)	72 (100%)	150 (100%)

TABLE 4

CLINICAL AND PATHOLOGIC COMPARISON OF MALIGNANT AND BENIGN DISEASE

Biopsy Diagnosis	*Palpable Nodes*	*Nonpalpable Nodes*	*Total*
Cancer present	37 (48%)	7 (10%)	44 (30%)
Non-neoplastic diagnoses	18 (22%)	4 (5.5%)	22 (14%)
Total definitive diagnoses	55 (70%)	11 (5.5%)	66 (44%)
Total biopsies	78 (100%)	72 (100%)	150 (100%)

TABLE 5

COMPARISON OF BIOPSY WITH INITIAL DIAGNOSIS

	Palpable Nodes	*Nonpalpable Nodes*	*Total Cases*
Confirmed initial diagnosis	35 (45%)	8 (11%)	43 (29%)
Compatible with initial diagnosis	9 (12%)	4 (6%)	13 (9%)
Differed from initial diagnosis	9 (12%)	1 (1.5%)	10 (7%)
Total diagnostic biopsies	53 (68%)	13 (18%)	66 (44%)
Total nondiagnostic biopsies	25 (32%)	59 (82%)	84 (56%)
Total cases	78 (100%)	72 (100%)	150 (100%)

TABLE 6

PROPORTION OF POSITIVE BIOPSIES IN CARCINOMA WITH AND WTHOUT PALPABLE LYMPH NODES

Diagnosis	*Palpable Nodes*	*Nonpalpable Nodes*	*Total Cases*
Bronchogenic carcinoma (initial diagnosis)	24 of 37 (65%)	7 of 54 (13%)	31 of 91 (34%)
Bronchogenic carcinoma (final diagnosis)	25 of 33 (75%)	7 of 42 (17%)	32 of 75 (43%)
Other carcinoma (final diagnosis)	12 of 14 (85%)	0 of 4 (0%)	12 of 18 (67%)

histologic section of the scalene node showed non-caseating granuloma. He ultimately was proven to have tuberculosis without cancer.

Table 6. A *preoperative* diagnosis of bronchogenic carcinoma associated with palpable scalene nodes was followed by a 65% incidence of definitive histologic confirmation from scalene nodal biopsy. When there were no nodes palpable, however, only 13% of scalene lymph nodes contained carcinoma. Among 91 patients with the preoperative diagnosis of bronchogenic carcinoma, 34% had biopsies showing carcinoma.

When the *final* diagnosis was carcinoma of the lung, 75% of biopsies of palpable nodes showed cancer, but only 17% of biopsies of nonpalpable nodes showed cancer. In the latter situation without palpable nodes, four of six biopsies were positive in patients with diffuse bronchogenic carcinoma, whereas only three of 29 biopsies were positive in the presence of early lesions which were located in a single lobe. Six "Pancoast tumors" without palpable nodes had negative scalene nodal biopsies. When the final diagnosis was carcinoma other than of the lung, 85% of patients with palpable nodes and none of the four without palpable nodes showed the neoplasm.

Side of Metastasis from Pulmonary Cancer

Twenty-six patients having scalene nodal biopsies showing cancer from unifocal bronchogenic carcinoma were analyzed to determine the side of metastasis. Table 7 lists the location of 26 bronchogenic carcinomas with scalene nodal metastasis and the side of metastasis. Twenty (77%) of the cases metastasized to the side predicted by the classic lymphatic drainage described by Rouviere[9] and Drinker.[10] Three of the six cases which did not metastasize in the classic manner were located in the hilar region where there is an extensive communication between the hilar lymphatics which might account for this phenomenon.[11]

TABLE 7

SIDE OF SCALENE NODE METASTASIS IN BRONCHOGENIC CARCINOMA

Location of Tumor	*Scalene Node* RIGHT	LEFT
Right upper lobe	3	1
Right middle lobe	0	1
Right lower lobe	1	1
Right hilum	4	2
Left upper lobe	0	7
Left lower lobe	2	0
Left hilum	1	3
Total	11	15

Discussion

The incidence of definitive diagnosis from scalene nodal biopsies depends upon the selection of patients, the frequency of bilateral dissections and the frequency of palpable nodes. Reviews of the literature indicate a wide divergence of positive results (9% to 54%).[12] Our findings are similar to the 34% reported by Thomas *et al*[11] and the 35% noted by Skinner.[7] While there is good agreement about the advisability of performing scalene lymph nodal biopsy in the presence of palpable nodes, disagreement exists concerning the biopsy of nonpalpable nodes. Skinner[7] concluded that routine scalene nodal biopsies in the absence of palpable nodes were not indicated before thoracotomy for potentially curable bronchogenic carcinoma, since the incidence of positive biopsies was only 6%. Others have noted positive biopsy rates of 6.3% to 11% on similarly selected cases.[13-15]

Thomas[11] and Yee *et al*[3] reported positive scalene nodal biopsies in 19% and 21.4% of cases respectively when bronchogenic carcinoma existed without palpable nodes. They advocated routine biopsies to rule out metastasis. Although our experience indicates a 17% incidence of positive biopsies with bronchogenic carcinoma in the absence of palpable nodes, we cannot recommend the routine use of scalene nodal biopsy because of the selected nature of the patient population. When bronchogenic carcinoma is diffuse and not localized to a single lobe, however, routine biopsy is justified because of the 4%-to-12% mortality rate following thoracotomies for nonresectable carcinoma of the lung.[16]

It is of some interest that on the basis of the scalene node biopsy, the preoperative diagnosis was proven incorrect in only one of 72 cases in which the lymph nodes were not palpable preoperatively, whereas in 78 cases with palpable nodes, the biopsy was instrumental in changing the preoperative diagnosis in 12% of patients. Nevertheless, the initial diagnosis was supported by the scalene nodal biopsy in 17% of the cases with nonpalpable nodes.

Several series reported show that 4% to 6% of specimens contained no lymph nodes.[3, 7, 11] The 8% incidence reported in this study reinforces the need for meticulous and proper dissection to insure that adequate tissue is obtained for examination. The choice of a biopsy site is easily made in the presence of palpable nodes, but when the nodes are not palpable the choice is more difficult. Usually the classical pathways of lymphatic drainage from the lung as described by Rouviere[9] and Drinker[10] and recently reviewed by Paulson[16] are used to guide the operator. As a rule, all pulmonary lobes drain to the right scalene lymph node except for the left upper lobe which drains to the left side. However, extensive communications have been described in the hilar region and may account for reports indicating that metastases from bronchogenic carcinoma do not follow the classic pattern.[3, 11, 17]

The findings in this series agree with the classical direction of metastasis in 77% or more of cases. Bilateral dissections were not performed routinely because it was unusual to have bilateral palpable nodes and, thus, unlikely that the side without palpable nodes would be a major site of metastasis.

(Continued on page 497)

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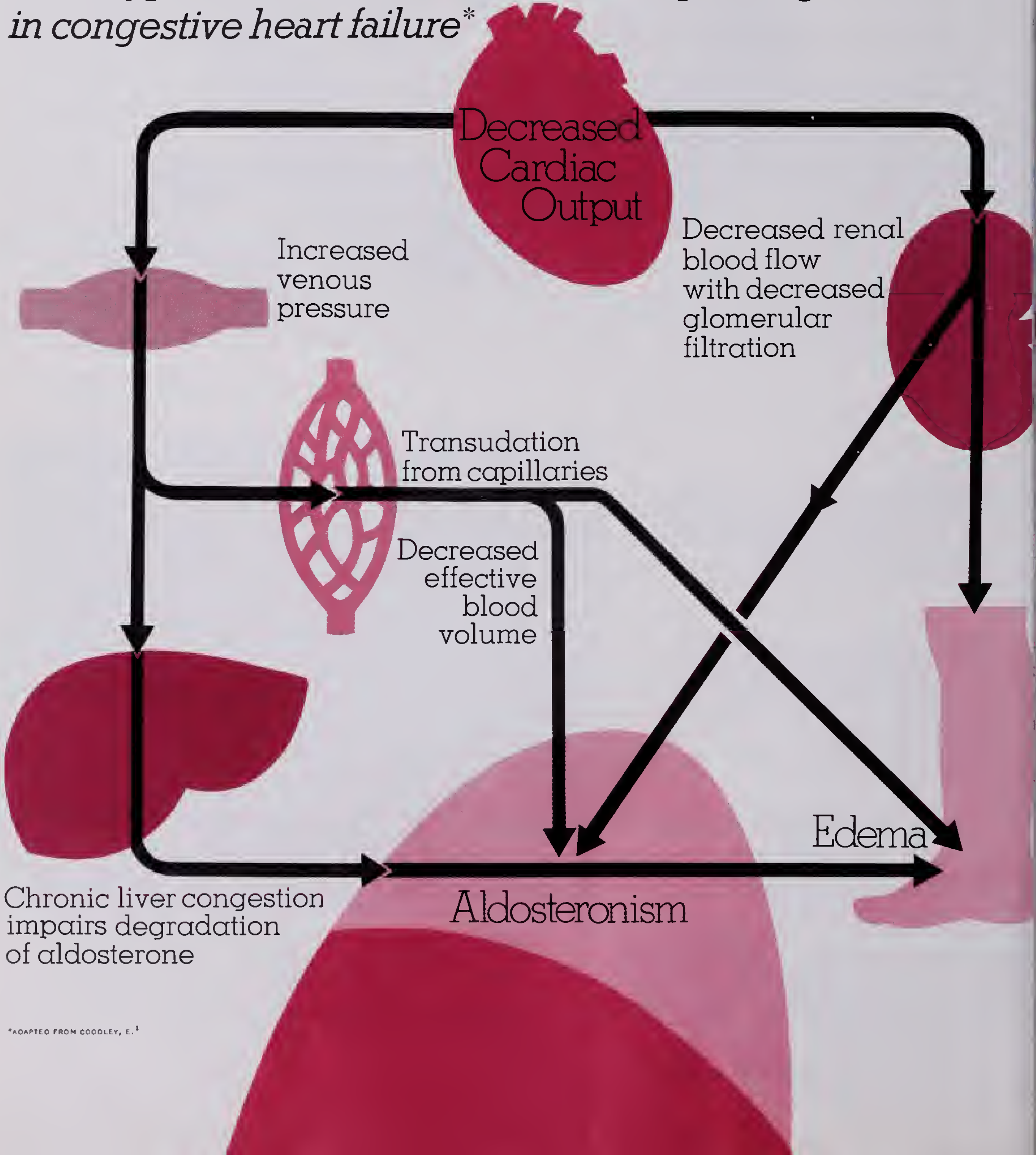

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Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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GERALD MEDOFF, M.D., ***St. Louis***

Pneumonia Caused by a Pneumococcus Resistant to Erythromycin and Lincomycin

Case Report

This article presents a case report of pneumonia caused by a Diplococcus pneumoniae, Type 13, which was resistant to erythromycin and lincomycin. The author is from the Division of Infectious Diseases, Department of Medicine, Washington University School of Medicine.

ALTHOUGH PENICILLIN is the preferred treatment for pneumococcal infections, erythromycin or lincomycin are frequently used, particularly in patients who are allergic to penicillin. There have been two reports in the English literature of *Diplococcus pneumoniae* resistant to erthromycin.[1, 2] Only one described a clinical infection. This report describes a case of pneumonia caused by an erythromycin- and lincomycin-resistant pneumococcus in a patient with multiple myeloma.

CASE REPORT

A 69-year-old physician was admitted to Barnes Hospital on Dec. 27, 1971 for evaluation of lumbar back pain of three weeks duration. In 1965, he was treated for cancer of the prostate with orchiectomy and stilbestrol. Following this, he felt well and returned to an active medical practice until the onset of his back pain. Physical examination on admission was unremarkable except for tenderness over the lumbar area. X-rays of the lumbar spine showed an osteolytic fracture of L_1. A bone marrow examination showed abnormal plasma cells diagnostic of multiple myeloma. He had light chain globulin fractions in his urine and a monoclonal gamma spike on immunoelectrophoresis. He was treated with phenylalanine mustard and local irradiation to his lumbar spine with decrease in his back pain. On January 8, just prior to discharge from the hospital, he spiked a temperature to 102F. A chest x-ray 24 hours later showed a small right upper lobe infiltrate. The patient was unable to produce sputum and, because he was allergic to penicillin, he was treated empirically with erythromycin 250 mg p. o. every six hours. After a transient improvement, fever returned 24 hours later and the patient appeared to be more toxic. Sputum was obtained. It showed gram positive diplococci, but grew only α streptococci on culture. The infiltrate on the chest x-ray increased in size and the erythromycin (erythrocin lactobionate) dosage was increased to 1 gm every six hours and given intravenously, and intramuscular injections of 80 mg of gentamicin every eight hours was added. Fever continued and the infiltrate increased further in size. A lung aspiration and bronchoscopy were performed and the material from these procedures also showed gram positive diplococci. These later grew *D. pneumoniae*, Type 13. On the basis of the gram stain, it was decided to treat the patient with penicillin. Because skin tests using cephalosporin (Keflin®) and penicillin were positive, a desensitization program for penicillin was initiated and 12 hours later, the patient was placed on a constant intravenous infusion of 20 million units of aqueous penicillin per day. He was improved 24 hours after penicillin therapy was started and he continued to improve during the next two weeks of treatment. He felt well when discharged from the hospital on Jan. 30, 1972 with a normal chest x-ray.

Disk sensitivities on the organism isolated from the sputum showed it to be resistant to erythromycin and lincomycin. Tube diluation sensitivities were done using standard inoculums of 10^3 and 10^5 organism in trypticase soy broth and 10% calf serum. The organism was resistant to greater than 50 μg/ml of erythromycin and lincomycin.

DISCUSSION

Antibiotic sensitivity testing is not routinely done on isolates of *D. pneumoniae*. On the basis of periodic screening, however, it is known that approximately 5% are resistant to tetracycline and a much lower percentage are resistant to erythromycin.[3] Recently, there have been reports of strains resistant to penicillin.[4] In the case reported here, there were both in vitro resistance and a failure of clinical response to erythromycin.

Because of the infrequency of occurrence of strains of *D. pneumoniae* resistant to penicillin, erythromycin and tetracycline, routine antibiotic sensitivity testing of this bacteria probably is unnecessary.[3] However, periodic monitoring of isolates probably should be done and, certainly, in a situation in which there is an inadequate clinical response, the organism should be tested for sensitivity to the antibiotics being used.

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Polypectomy

(Continued from page 490)

those reported in the literature and by personal communication to the senior author. Advantages regarding decreased expense to the patient and reduced hospital stay have been stressed.

Addendum: As of July 8, 1974, the authors have performed successful polypectomies on 40 patients, including Patients #22 and #24 who had had unsuccessful polypectomies. One polyp proved to be a lipoma and another a leiomyoma. There have been no additional complications.

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Scalene Lymph Nodes

(Continued from page 494)

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JOSEPH C. EDWARDS, M.D., ***St. Louis***

Use of Diazoxide for Refractory Hypertension

Case Reports

Diazoxide (Hyperstat®), a nondiuretic benzothiadiazine derivative,[1, 2] has been under clinical trial for several years as an adjunct in the management of patients with severe or accelerated phase (malignant) hypertensive disease. Combinations of other antihypertensive drugs administered to these patients have failed to control the systolic and diastolic blood pressure. Diazoxide has been shown not to produce any long-term hyperglycemic effect in man,[3–5] or any diabetes[6] when given in a series of rapid injections for a period of several days for the treatment of intractable hypertension. It is particularly useful when the patient has serious involvement, rising blood urea nitrogen (BUN), headache and accelerated phase of hypertension. There is no increase in BUN as a result of these injections.[7] Reduction of elevated blood pressure is accompanied, in some instances, by an increase of plasma uric acid that did not precipitate gout.[6] There is an increase in cardiac output and rate.

Method of Administration

The usual dose of diazoxide is 300 mg in 20 ml of solution, given intravenously in 10 to 15 seconds in one or, possibly, two injections on the same day or on two successive days.

This is continued if the blood pressure remains elevated, particularly when diastolic pressure again rises to levels of 110 mm to 120 mm or above.[6] Another injection should be given every day or two to three days apart whenever the elevation recurs and until as many as five to ten injections have been given. The total dose in one or more injections of diazoxide required to produce satisfactory control of blood pressure for a few days varied from 300 mg to 1.2 gm in our experience and in that of others.[6–8]

After clinical trial for several years, diazoxide has proved to be an effective, safe agent as an adjunct in the management of severe or accelerated hypertensive disease and in hypertensive crises. It also has been recommended for use in hypertensive patients who will undergo diagnostic procedures, such as renal biopsy or arteriography, and for temporary reduction of blood pressure. Dr. Edwards is Assistant Professor of Clinical Medicine, Washington University School of Medicine.

Diazoxide is not to be administered intramuscularly or subcutaneously. The maximum reduction of blood pressure usually occurs within five minutes after the injection, so the blood pressure should be monitored every minute to two minutes for the first ten minutes and after that, at five-minute intervals until it stabilizes. It is then followed every four hours while the patient is awake to monitor the course and subsequent effect on the blood pressure and to determine when another drug might be indicated. The blood pressure stays at the lower level for four to six hours and, finally, longer.

Failure of the patient to respond with a fall in blood pressure after diazoxide injection was not encountered in this or other reports.[6, 9] Later, even though the pressure rises, it allows the other drugs to be more effective. In small or debilitated individuals or children, the dose is approximately 5 mg per kilogram of body weight.

Indications

Diazoxide is especially advisable in the emergency treatment of hypertensive crises associated with acute congestive heart failure, acute hypertensive encephalopathy, acute glomerulonephritis, toxemia of pregnancy with eclampsia, cerebral hemorrhage or hypertensive episodes of pheochromocytomas. It also has been recommended for use in hypertensive patients who will undergo diagnostic procedures, such as renal biopsy or arteriography, and for temporary reduction of the blood pressure.

The injection does not interfere with hemostatic mechanisms but maintains blood pressure during anesthesia for vaginal delivery or Caesarean section. It is not intended to supplant other antihypertensive therapy. Restriction of dietary protein was used in those with low creatinine clearances. Sodium retention may be treated with daily single doses of furosemide or ethacrynic acid. Diets restricted to 1 gm of sodium chloride in the daily diet were used only as a last resort. Diabetic diets were not needed. Daily urine tests with clinitest tablets and blood sugar tests were used frequently in hospital patients and at regular intervals in outpatients to detect hyperglycemia.

Contraindications

Contraindications, of course, include any allergic reaction to the thiadiazine group of drugs or specifically to diazoxide. Diazoxide must be used with caution in the presence of severe coronary disease, especially during acute myocardial infarction. It should be used with caution to avoid any abrupt reduction of blood pressure or actual hypotension. Because of the lack of proof of fetal safety and because not enough experimental work has been done in animals, it is to be avoided in the first six months of pregnancy unless it is considered to be a life-saving measure during a life-threatening crisis.[10] Administration of the compound is avoided in diabetic hypertensives, except when the danger of hypertension may be considered life-threatening compared to the possible aggravation of the diabetes. The oral preparation is not used over a long term because it seems to have a more prolonged hyperglycemic effect than when given intravenously. There are reports to the contrary when tolbutamide was used in conjunction with oral diazoxide.[4, 9]

Discussion

The new antihypertensive medications will be of more permanent benefit where there is no severe underlying disease that continues progressively. It is only by further research into the causes of essential hypertension that we can find more adequate control of prevention of such degenerative changes. The advances in high blood pressure treatment have allowed people with severe hypertensive disease to survive for longer periods of time. The causes of death have shifted from heart failure and cerebral hemorrhage to terminal renal failure and atherosclerotic complications. Diazoxide often will allow the control of the high blood pressure with lower doses of the common antihypertensive drugs for a brief period, at least. Whether it offers any permanent advantage in control of hypertension requires more long-term observations. It is helpful in in acute hypertensive crises and acute pulmonary edema in the presence of severe hypertension or cerebral hemorrhage.

Case Reports

Case #1. The first patient, a 48-year-old white salesman, was first found to have high blood pressure (160/100) in 1957. He was refused insurance after an examination on April 27, 1964 revealed blood pressure of 260/170 mm Hg. When he was admitted to Barnes Hospital on Nov. 3, 1966, there was papilledema, with two flame-shaped hemorrhages in the left optic fundus. The presence of pheochromocytoma was excluded by normal VMA and catecholamines. Renal artery stenosis was excluded by normal renal arteriograms. Intravenous pyelograms showed no contrast in one and two minute films but there was fair visualization of normal renal structures in five minutes and better visualization in 20 minutes. Urine cultures were negative. The first dose of 300 mg diazoxide was given on March 4, 1968, when the BUN was 186 mg/100 ml. After 34 exchanges during peritoneal dialysis on March 7 and 8, 1968, the BUN decreased from 220 mg/100 ml to 66 mg/100 ml. The blood pressure decreased to 150/80 for 12 hours and then increased to 190/120. Creatinine

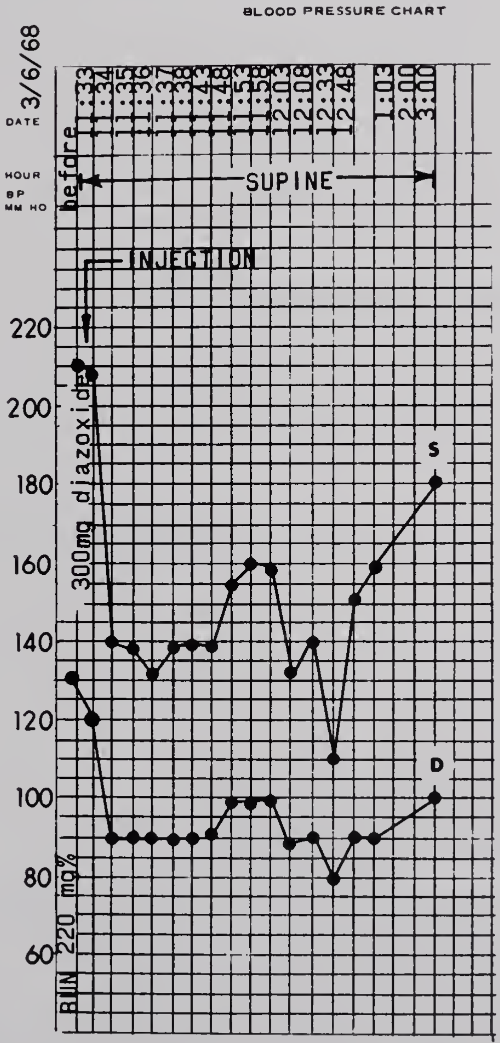

Fig. 1 Case #1. March 6, 1968. Response in patient to diazoxide within minutes after fifth intravenous injection.

TABLE 1

BLOOD PRESSURES BEFORE AND AFTER 300 mg DIAZOXIDE IV

Patient No.	Lbs. Wt.	Age	Sex	Race	B.P. on Admission		Grade of Hyper-tension	Dialysis	BUN	B.P. Before Diazoxide		B.P. 2 min. After Diazoxide		B.P. 24 hrs. After Diazoxide		300 mg. ea. Total Injections
					Syst.	Diast.				Syst.	Diast.	Syst.	Diast.	Syst.	Diast.	
1	138	48	M	W	290	196	IV		186	*196	130	170	100	180	130	
										*180	130	130	90	180	130	
								yes		*210	140	140	90	160	110	
									66	*180	120	140	80	160	100	12
2	190	38	M	B	220	180	IV		53	134	120	140	90	160	100	
									21	170	120	130	80	130	80	17
3	139	56	F	W	250	180	IV		61	270	130	170	80	220	130	
										220	130	140	80	170	100+.120	2
4	112	16	F	W	200	140	IV		16	*190	130	150	70	200	130	
									26	*200	130	180	110	200	80	3
5	160	51	M	W	210	130	IV		70	230	140	150	80	190	110	15
									32							
6	146	46	F	B	210	170	IV			200	150	170	90	170	120	1
7	210	38	M	W	230	150	IV		110	220	150	190	120	180	120	
										180	120	150	100	160	120	3
										214	124	180	98	170	100	
8	110	35	M	W	230	150	IV		108	210	130	210	130	170	110	
										180	130	130	80	170	110	4
										180	120	150	80	150	120	
										180	120	150	85	160	100	
9	160	29	M	W	250	140	IV		60	210	130	145	85	180	108	9
									100	200	130	134	78	150	100	
										192	130	130	70	108	64	
										198	120	130	72	140	96	
10	119	25	F	W	196	122	IV	Peritoneal yes	83	170	120	100	50	148	88	1
11	180	33	F	W	268	155	IV		31	225	130	225	125	190	120	
										260	155	210	140	170	104	2
12	145	51	M	W	250	140	IV		45	250	140	210	105	228	130	
									50	228	130	195	110	232	120	
										232	126	205	105	190	110	14
										212	112	170	90	200	100	
13	178	25	F	W	220	140	IV		23	220	140	160	110	160	110	
					240	150	IV		35	220	150	160	60	200	130	3
										210	150	165	110	160	120	
14	181	39	M	B	250	170	IV	yes	219	200	120	180	80	290	120	1
									26							(400 mg)
								Renal	141							
									81							
									78	196	120					
												Post.	Dial.	170	120	

Patient No. 1. * indicate 1st, 5th, 8th, & 9th
Patient No. 4. * indicate 1st, & 3rd

clearance was 3.2 cc per minute and BUN was 94 mg/100 ml (Figs. 1 & 2).

The patient received 50 mg of guanethidine daily, 500 mg of alpha methyl dopa four times daily, 0.25 mg of digoxin daily, 25 mg of spironolactone five times daily and 100 mg allopurinol twice daily; 15 cc of 10% KCL solution was needed at times, but with poor renal function, the potassium was not decreased markedly by the diuretics. Twelve intravenous injections of diazoxide were administered.

The results are summarized in Table 1 with results on 13 other patients. Table 2 records the blood and urine concentrations of diazoxide in Patient #1. He died on Nov. 27, 1968.

Autopsy revealed severe arteriolar nephrosclerosis of the kidneys with fibrinoid necrosis of some of the small thickened renal vessels consistent with his clinical course of malignant or accelerated phase hypertension. There was severe stenosing atherosclerosis of the coronary arteries and atherosclerosis of aorta.

TABLE 2
CASE #1

	Diazoxide in Blood	
3-25-68	(Date of last previous injection of diazoxide, 300 mg)	
4- 1-68	(Before next diazoxide injection)	5.21 gamma per ml blood
	1 min after inject, IV	40.75 gamma per ml blood
	2 min after inject, IV	23.62 gamma per ml blood
	3 min after inject, IV	23.68 gamma per ml blood
	15 min after inject, IV	16.70 gamma per ml blood
	30 min after inject, IV	15.75 gamma per ml blood
	45 min after inject, IV	14.78 gamma per ml blood
	60 min after inject, IV	16.36 gamma per ml blood
	60 (repeat dtn)	16.50 gamma per ml blood
	120 min after inject	13.94 gamma per ml blood
	180 min after inject	13.60 gamma per ml blood
4- 2-68	12 noon (20 hr 20 min after injection)	13.30 gamma per ml blood
4- 3-68	12 noon (44 hr 20 min after injection)	9.71 gamma per ml blood
	Diazoxide in Urine	
4- 1-68	(24 hour urine)	28.35 gamma per ml urine
4- 3-68	(24 hour urine)	12.89 gamma per ml urine

TABLE 3
DIAZOXIDE IN BLOOD
300 mg IV

	Case #1 *BUN 53 to 66 mg percent*		
4- 5-68	25 hrs after injection	13.04 gamma per ml blood	
4- 6-68	48 hrs after injection	13.19 gamma per ml blood	
4- 9-68	Before injection	6.31 gamma per ml blood	
4- 9-68	1 min after injection	25.00 gamma per ml blood	
4- 9-68	3 min after injection	19.43 gamma per ml blood	
4- 9-68	1 hr after injection	14.56 gamma per ml blood	
4-10-68	38 hrs after injection	11.72 gamma per ml blood	
	Case #2 *BUN 53 to 21 mg percent*		
2-20-70	25 hrs after injection	20.48 gamma per ml blood	
3- 3-70	6½ days after injection	2.92 gamma per ml blood	
	DIAZOXIDE IN URINE		
	Case #1 *Creatinine clearance 9 cc/min*		
4- 5-68	25 hrs after injection	18.30 gamma per ml urine	(112 ml)
4- 6-68	48 hrs after injection	26.35 gamma per ml urine	(65 ml)
4- 9-68	12 to 36 hrs after injection	20.46 gamma per ml urine	(1558 ml)
4-10-68	48 hrs after injection	30.19 gamma per ml urine	(160 ml)
	Case #2 *BUN 53 to 21 mg percent*		
2-20-70	25 hrs after injection	23.0 gamma per ml urine	
3- 3-70	6½ days after injection	11.72 gamma per ml urine	

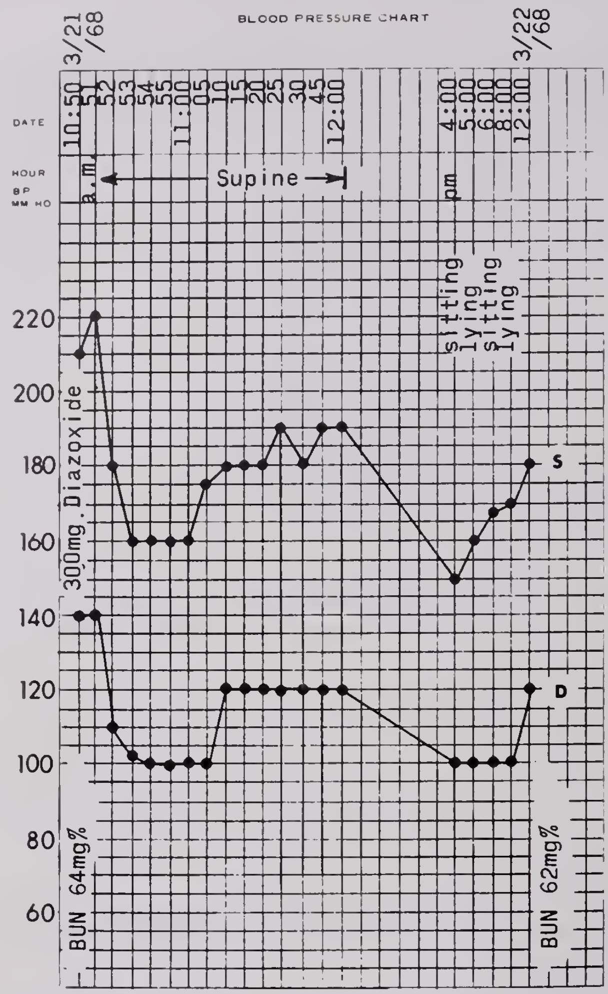

Fig. 2 Case #1. March 21, 1968. Response to eighth intravenous injection of diazoxide.

Case #2. The second patient was a 35-year-old black grave digger with congestive heart failure and a diastolic blood pressure of 180 mm Hg. Creatinine clearance was 41 ml per minute. Intravenous pyelograms were normal. He received 400 mg of hydralazine in divided doses daily, 50 mg of hydrochlorothiazide daily, 250 mg of alpha methyl dopa four times daily, 40 mg of guanethidine per day and 15 cc of 10% solution of KCl four times daily. Later, 40 mg of furosemide was substituted each morning for the hydrochlorothiazide. The blood pressure response of this patient is shown in Fig. 3. The blood and urine levels of diazoxide is illustrated on Table 3.

Table 1 summarizes the results of the use of diazoxide intravenously in 14 patients with grade IV hypertension.

The individual response of the first two patients with severe accelerated phase hypertensive disease to the rapid intravenous injection of 300 mg of diazoxide is illustrated in Figs. 1, 2 and 3. Twelve other patients had similar decreases in blood pressure following the administration of diazoxide intravenously.

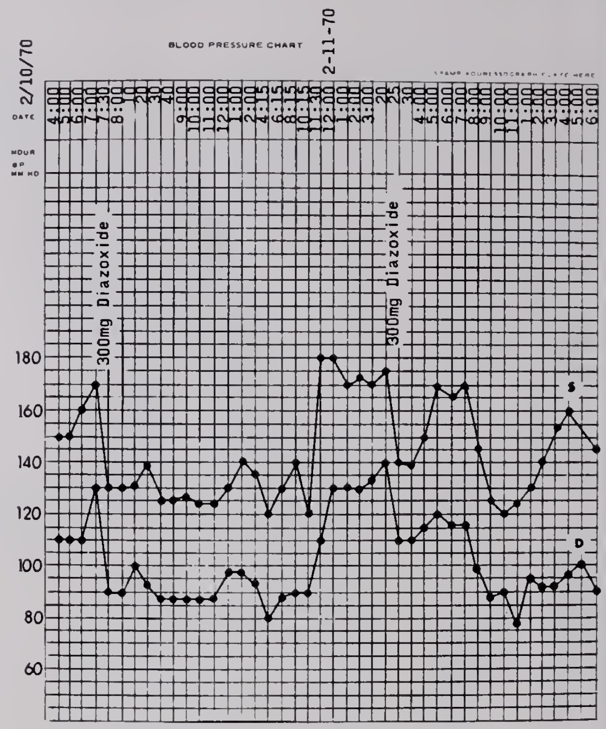

Fig. 3 Case #2. Response to 300 mg of diazoxide administered intravenously.

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1. Gertler, M. M., et al.: Geriatrics *25:*134-148 (May) 1970.

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President's Message

Probably the biggest fraud that has ever been perpetrated on the American Doctor is the substitution of the word "health" for the word "illness."

Health insurance doesn't insure against health; it insures against illness. It would make just as much sense to call your auto insurance safety insurance instead of accident insurance or your malpractice insurance PERFECT-RESULTS-EVERY-TIME INSURANCE.

This, in itself, would not be too bad except that it has led to an error in thinking by the American Public, the Social Planners and many physicians.

The simple truth is that physicians are not experts in health. They are experts in treating disease, and the maintenance of health is only occasionally within the sphere of the physician.

The treatment of lung cancer is surgery or radiation, but the maintenance of health against lung cancer is education against smoking.

The care of automobile accident victims is clearly medical. Prevention of automobile accidents is an automobile engineering, judicial and legislative function. At this writing, the 55-mph speed limit has cut the death rate from automobile accidents in half. This simple piece of legislation has done more for health maintenance than could have been accomplished by a completely equipped and staffed emergency hospital at every major intersection.

James C. Cope, M.D.

Health maintenance requires clean air, pure water, adequate housing and protective clothing. Simply calling a closed-panel medical practice a Health Maintenance Organiztion is not going to change the nature of the organization or suddenly improve the nation's health.

Don't be fooled by semantics. Sanitary engineers, nutritionists, ecologists, environmentalists, educators and public health workers are health experts. When these fail and a person becomes ill, he needs an illness expert. He needs a Doctor.

Woman's Auxiliary

50th Anniversary

TOGETHERNESS IS A VIRTUE

"Together, we can do much more." This is the slogan of the membership committee for the Woman's Auxiliary to the American Medical Association. When you realize that there are 90,000 women in this group, you can appreciate the validity of the statement.

Together, we members in Missouri won an award for achieving our goal for the AMA Education and Research Foundation. The Missouri Auxiliary gave a total of over $18,000 or a per capita donation of $11.73 to the AMA-ERF. Together, the Auxiliary to the AMA gave a total of $1.2 million to the AMA-ERF.

Mrs. George J. Lytton
President

"But, we want to work with the hospital auxiliary." This is a common "reason" projected by many doctors' wives who choose not to join our MSMA Auxiliary. If they could understand that we can offer ways to help hospital auxiliaries, perhaps these women would take advantage of MSMA Auxiliary membership. We offer package programs on pertinent medical subjects which can broaden the knowledge of non-medical auxiliary members. Together, we also can expand the horizons of all non-medical groups in which we work.

Together, we must remember that one of our MSMA Auxiliary objectives is to "extend the aims of the Missouri State Medical Association in its programs for the advancement of medicine and public health." We need the encouragement and moral support of the doctors of Missouri to help us achieve our goals. Please urge your wives to support the goals and objectives of the Woman's Auxiliary.

Together, we can do much more.

EDITORIAL

THE IRON FIST

When Medicare and Medicaid were adopted back in 1965, assurances were given that these programs would not lead on to government control of medicine.

That guarantee, indeed, was written into the legislation. The bill explicitly said nothing in its language "shall be construed to authorize any federal officer or employe to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."

This had a pleasantly soothing sound, and people who warned against potential government takeover were dismissed as cranks.

Less than ten years later, those early warnings of government coercion are all in the process of coming true.

The bureaucrats of the Department of Health, Education and Welfare are deploying a massive network of "Professional Standards Review Organizations" to control the private practice of medicine down to the last detail. And the pretext, exactly according to the crank scenario, is that such control has become essential because of Medicare and Medicaid.

As just about everyone knows by now, these programs of medical subsidy have run far ahead of original estimates and are costing the nation billions of dollars in tax money. (Another warning which was blandly ignored back there in '65.) And in an effort to get these costs under some kind of control, the federal planners have come up with the PSRO scheme to regulate everything and everybody which is or "may be" financed with government medical dollars.

PSRO is a vast bureaucratic pyramid allegedly relying on doctors themselves but controlled by the Secretary of HEW. Among other things, it will maintain computerized files on doctors and patients, establish "norms" of standardized medical care and hand out punishments to medical practitioners whose treatments vary from the lowest common denominator.

HEW will also have access to medical records as it sees fit, thereby violating at its whim the confidential relationship between doctor and patient.

Justification for all this is simplicity itself. As the HEW official in charge of imposing the controls has put it: "The government is paying for a significant amount of medical care. It wants to see that the care being received is appropriate." Which is another way of saying that, within the velvet glove of federal subsidy, there always lurks the first of federal control.

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County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

The Buchanan County Medical Society and the Northwest Missouri Dental Society held their 22nd annual joint meeting on May 1. The event was a dinner and scientific program presented at the St. Joseph Country Club.

Sixty-two physicians and dentists from St. Joseph and Northwest Missouri attended.

President Randal W. Weed of the Medical Society and Dr. Gweldon Long of Maryville, president of the Dental Society, presided jointly.

Speaker for the evening was Dr. Charley W. Norris, Associate Professor in the Department of Otorhinolaryngology, University of Kansas Medical Center. He addressed members of the two professions on "Newer Concepts in the Management of Sarcoma." He particularly discussed the treatment of tumors in the head and neck.

The speaker was introduced by Dr. Robert R. Stuber, a member of the Medical Society's program committee.

John T. Rogers, M.D., *Secretary*

Grand River Medical Society

The Grand River Medical Society met on June 13 at the Chillicothe Country Club. Fourteen physicians and members of the Woman's Auxiliary attended the meeting.

After the social hour and dinner, Dr. John Platz, president, introduced Dr. Watkins A. Broyles of Bethany, who is the Society's new 50-Year Member and who wore his 50-year pin at the meeting.

The scientific speaker for the evening was Boyd Terry, M.D. who discussed "Treatment of Burns" and the development of the new Burn Center at the University of Missouri-Columbia School of Medicine.

George Mandler, M.D., *Secretary*

NINTH DISTRICT

COUNCILOR
CLAUDE W. COOPER, M.D., THAYER

Mid-Missouri Medical Society

The Mid-Missouri Medical Society met on May 16 at the Oak Meadow Country Club in Rolla.

The minutes of the previous meeting were read and approved.

Dr. Frank A. Elders read a resolution which had been passed at the 116th Annual Session of the MSMA. The resolution calls for compulsory AMA membership for MSMA members. Dr. Elders moved that the society send a letter to the Ninth District Councilor indicating that the Mid-Missouri Medical Society does not approve the resolution. It also was moved to notify other members of the Councilor District of this resolution. Dr. E. F. White seconded the motion. The motion passed.

Dr. Elders moved that the officers of the Society meet with the corresponding officers of the Osteopathic Association in the area to explore possibilities of a joint meeting. Dr. White seconded the motion and it was passed by a vote of five to one.

Dr. White moved that the Society send a representative to the Blue Shield meeting to observe and report to the Society. The motion was seconded and passed

Dr. James R. Butts moved that the next meeting be held in Rolla. Dr. James M. Myers seconded the motion and it was approved. A later motion was made to accept an invitation to meet at Ft. Leonard Wood in September.

As guest speaker, Dr. Joe Thompson of Ft. Leonard Wood discussed his experiences in treating alcoholism.

Bernard Draper, M.D., *Secretary*

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Mineral Area Medical Society

The Mineral Area Medical Society entertained members of the Woman's Auxiliary at the Annual Spring Banquet at the St. Francois Country Club on April 30.

Featured on the program was a scientific paper, "The Psychological Basis of Custer's Last Stand," which was presented by Prof. Charles Hofling, M.D., Professor of Psychiatry at St. Louis University.

Members and guests who attended the banquet meeting were Dr. and Mrs. Hofling; Dr. Norma D. Farmer, President; Dr. and Mrs. H. D. Dierker, Dr. and Mrs. A. R. Rao, Dr. and Mrs. Jay Tuttle, Dr. and Mrs. Metin Arat, Dr. and Mrs. Jack Mullen, Dr. and Mrs. Talaban, Dr. and Mrs. Stan Hardy, Mrs. George Dent, Dr. and Mrs. T. R. Burcham, Dr. and Mrs. M. A. Grossman, Dr. and Mrs. A. G. Karraker, Dr. and Mrs. C. W. Chastain, Dr. and Mrs. C. E. Carleton, Dr. and Mrs. F. R. Crouch, Dr. and Mrs. G. A. Oliver and Dr. and Mrs. Paul Dennis.

C. W. Chastain, M.D., *Secretary*

New Members

Proceso T. Arenos, Jr., M.D., 3015 N. Ballas, St. Louis, has become a member of St. Louis County Medical Society. Dr. Arenos is a native of the Philippines, received his preliminary education at Far Eastern University and his M.D. degree at Far Eastern University in 1968. He specializes in general surgery.

Romeo F. Arribas, M.D., 1212 10th, Blue Springs, has become a member of Jackson County Medical Society. Dr. Arribas is a native of the Philippines, received his preliminary education at Far Eastern University and his M.D. degree at Far Eastern University in 1967. He specializes in general surgery.

Steven H. Behrends, M.D., 24th and Cherry, has become a member of Jackson County Medical Society. Dr. Behrends is a native of Mountain Lake, Minn., received his preliminary education at Tabor College and his M.D. degree at the University of Kansas in 1972. He specializes in general surgery.

Egbert R. Borja, M.D., Lynn at Robberson, Springfield, has become a member of Greene County Medical Society. Dr. Borja is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1963. He specializes in internal medicine.

Donald W. Bussman, Jr., M.D., 1254 Bentoak, St. Louis, has become a member of St. Louis Medical Society. Dr. Bussman is a native of St. Louis, received his preliminary education at Holy Cross College and his M.D. degree at Washington University in 1973. He is an internist in surgery.

Antonio Campos, M.D., 6150 Oakland, St. Louis, has become a member of St. Louis Medical Society. Dr. Campos is a native of Mexico, received his preliminary education at the University of Chihuahua and his M.D. degree at the University of Chihuahua in 1969. He specializes in surgery.

Teddy G. Co, M.D., 10901 Winner Rd., Independence, has become a member of Jackson County Medical Society. Dr. Co is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1964. He specializes in pediatrics.

Reno R. Cova, Jr., M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Cova is a native of St. Louis, received his preliminary education at St. Louis University and his M.D. degree at the Stritch School of Medicine in 1968. He is a resident in neurosurgery.

Gordon B. Cutler, Jr., M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Cutler is a native of Ohio, received his preliminary education at Harvard College and his M.D. degree at Harvard Medical School in 1973. He is an internist in medicine.

Emil A. Difilippo, M.D., 14824 Wood Ford Way, Bridgeton, has become a member of St. Louis Medical Society. Dr. Difilippo is a native of Pennsylvania, received his preliminary education at Villanova University and his M.D. degree at St. Louis University in 1966. He specializes in orthopedic surgery.

Pricha Euprasert, M.D., 1212 10th, Blue Springs, has become a member of Jackson County Medical Society. Dr. Euprasert is a native of Bangkok, Thailand, received his preliminary education at the University of Medical Sciences and his M.D. degree at Siriraj Medical School in 1964. He specializes in general surgery.

Afonso C. Ferreira, M.D., 12867 Mariners Pt. Ct., St. Louis, has become a member of St. Louis County Medical Society. Dr. Ferreira is a native of São Paulo, Brazil, received his preliminary education at Colegio de Aplicacao and his M.D. degree at the Universidade De São Paulo in 1971. He specializes in surgery.

Roger L. Fink, M.D., 1423 N. Jefferson, Springfield, has become a member of Greene County Medical Society. Dr. Fink is a native of Omaha, Neb., received his preliminary education at the University of Nebraska and his M.D. degree at the University of Nebraska in 1965. He specializes in pathology.

William L. Frazier, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Frazier is a native of Indiana, received his preliminary education at Fisk University and his M.D. degree at Indiana University in 1968. He specializes in urology.

Lance Gerowin, M.D., 35 N. Central, St. Louis, has become a member of St. Louis Medical Society. Dr. Gerowin is a native of Ohio, received his preliminary education at Western Reserve University and his M.D. degree at the University of Michigan in 1966. He specializes in surgery.

Larry F. Glaser, M.D., 6724 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. Glaser is a native of Springfield, received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1967. He specializes in orthopedic surgery.

Jivanlal P. Gohil, M.D., 803 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Gohil is a native of India, received his preliminary education at Elphnstone College and his M.D. degree at Topihala National College in 1963. He specializes in psychiatry.

Jeffrey F. Goldenberg, M.D., 9222 Seneca, St. Louis, has become a member of St. Louis Medical Society. Dr. Goldenberg is a native of New York, received his preliminary education at the University of Pennsylvania and his M.D. degree at the University of Miami in 1973. He is a resident in obstetrics and gynecology.

Ronald K. Grady, M.D., 2821 N. Ballas Rd., St. Louis, has become a member of St. Louis County Medical Society. Dr. Grady is a native of Des Moines, Ia., received his preliminary education at Purdue University and his M.D. degree at Washington University in 1966. He specializes in internal medicine.

Jitendra K. Gupta, M.D., 777 S. New Ballas, St. Louis has become a member of St. Louis County Medical Society. Dr. Gupta is a native of India, received his preliminary education at the University of Agra and his M.D. degree at the University of Lucknow in 1963. He specializes in internal medicine.

Lanny W. Harris, M.D., 6400 Prospect, Kansas City, has become a member of Jackson County Medical Society. Dr. Harris is a native of Union City, Tenn., received his preliminary education at the University of Tennessee and his M.D. degree at the University of Tennessee in 1965. He specializes in orthopedic surgery.

Ronald Haun, M.D., 1465 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Haun is a native of St. Louis, received his preliminary education at Rose Polytechnic Institute and his M.D. degree at St. Louis University in 1973. He is an internist in pediatrics.

Richard A. Heimburger, M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. Heimburger is a native of St. Louis, received his preliminary education at Drury College and his M.D. degree at Vanderbilt University in 1961. He specializes in plastic surgery.

Barbel Holtmann, M.D., 4960 Audubon, St. Louis, has become a member of St. Louis Medical Society. Dr. Holtmann is a native of Germany, received her preliminary education at the University of Missouri and her M.D. degree at the University of Missouri in 1968. She specializes in plastic surgery.

Robert W. Hyatt, M.D., 807 Stadium Rd., Columbia, has become a member of Boone County Medical Society. Dr. Hyatt is a native of Sedalia, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1972. He is a resident physician.

Rene Julien, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Julien is a native of Haiti, received his preliminary education at Lycee Nord Alexis and his M.D. degree at Faculte de Medicine in 1964. He specializes in general surgery.

Harry S. L. Knopf, M.D., 211 N. Meramec, St. Louis, has become a member of St. Louis Medical Society. Dr. Knopf is a native of New Jersey, received his preliminary education at Harvard College and his M.D. degree at Harvard in 1967. He specializes in ophthalmology.

Kenneth Koldys, M.D., Doctor's Park, Cape Girardeau, has become a member of Cape Girardeau County Medical Society. Dr. Koldys is a native of Detroit, Mich., received his preliminary education at the University of Detroit and his M.D. degree at Wayne State University in 1967. He specializes in dermatology.

Robert Levitt, M.D., 510 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Levitt is a native of California, received his preliminary education at the University of California and his M.D. degree at the University of California in 1972. He specializes in radiology.

Bruce A. Lucas, M.D., 4960 Audubon, St. Louis, has become a member of St. Louis Medical Society. Dr. Lucas is a native of California, received his preliminary education at Duke University and his M.D. degree at Duke University in 1965. He specializes in urology.

Frank R. Luechtefeld, M.D., 510 Francis, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Luechtefeld is a native of Springfield, Ill., received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1968. He specializes in orthopedics.

Shirley McCluer, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. McCluer is a native of New Orleans, La., received her preliminary education at Louisiana State University and her M.D. degree at Louisiana State University in 1948. She specializes in physical medicine and rehabilitation.

Maria E. Manion, M.D., 1420 Grattan, St. Louis, has become a member of St. Louis Medical Society. Dr. Manion is a native of Argentina, received her preliminary education at Virgen Nina College and her M.D. degree at the University of Buenos Aires in 1961. She specializes in psychiatry and child psychiatry.

Robert M. Mathews, M.D., 6601 Rockhill Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Mathews is a native of Kansas City, received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1954. He specializes in general surgery.

Arthur N. Miller, M.D., 825 Euclid, Kansas City, has become a member of Jackson County Medical Society. Dr. Miller is a native of Philadelphia, Pa., received his preliminary education at Moravian College and his M.D. degree at the University of Pittsburgh in 1972. He specializes in general practice.

Victor G. Oceeno, M.D., 808 Euclid, Monett, has become a member of Ozarks County Medical Society. Dr. Oceeno is a native of the Philippines, received his preliminary education at Silliman University and his M.D. degree at the University of St. Thomas in 1958. He specializes in general surgery.

Anthony P. Pecoraro, M.D., 4320 Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Pecoraro is a native of Rochester, N. Y., received his preliminary education at the University of Rochester and his M.D. degree at the University of Missouri in 1968. He specializes in pediatrics.

V. Padmanabha Rao, M.D., 1636 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Rao is a native of India, received his preliminary education at the University of Mysore and his M.D. degree at Mysore Medical College in 1961. He specializes in thoracic and cardiovascular surgery.

Glen I. Reeves, M.D., 4502 Clayton Ave., St. Louis, has become a member of St. Louis Medical Society. Dr. Reeves is a native of Illinois, received his preliminary education at Columbia University and his M.D. degree at Columbia College in 1972. He specializes in general surgery.

Philip G. Rhodes, M.D., 24th and Gillham Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Rhodes is a native of Wichita, Kan., received his preliminary education at Friends University and his M.D. degree at the University of Kansas in 1970. He specializes in pediatrics.

Perry Roberts, M.D., Doctor's Park, Cape Girardeau, has become a member of Cape Girardeau County Medical Society. Dr. Roberts is a native of Lewiston, Utah, received his preliminary education at Utah State and his M.D. degree at Northwestern University in 1958. He specializes in otolaryngology.

William V. Roberts, Jr., M.D., 4950 Audubon, St. Louis, has become a member of St. Louis Medical Society. Dr. Roberts is a native of Texas, received his preliminary education at Ohio State University and his M.D. degree at Washington University in 1972. He specializes in psychiatry.

Vernon J. Roden, M.D., 649 Fieldston, St. Louis, has become a member of St. Louis Medical Society. Dr. Roden is a native of Ohio, received his preliminary education at the University of Notre Dame and his M.D. degree at St. Louis University in 1971. He specializes in pediatrics.

Anthony J. Romito, D.O., 5529 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. Romito is a native of St. Louis, received his preliminary education at the University of Missouri and his M.D. degree at the Kansas City College of Osteopathic Medicine in 1963. He specializes in family practice.

In Memoriam

Thelma C. Buckthorpe, M.D., Sikeston, a graduate of Washington University, 1930; member of Semo County Medical Society; age 73; died April 13, 1974.

Robert F. Shaw, M.D., 605 Wood Court, Liberty, a graduate of the University of Kansas, 1954; member of Clay County Medical Society; age 47; died April 16, 1974.

Homer F. Mundy, M.D., 5th and Francis, St. Joseph, a graduate of Bennett Medical College, 1911; member of Buchanan County Medical Society; age 92; died April 25, 1974.

Evan S. Connell, M.D., 837 W. 58th Terr., Kansas City, a graduate of Tulane University, 1913; member of Jackson County Medical Society; age 84; died April 30, 1974.

Harry R. Echterhoff, M.D., 6035 N. 10th, Phoenix, Ariz., a graduate of St. Louis University, 1927; member of St. Louis Medical Society; age 70; died May 4, 1974.

Norman Tobias, M.D., 634 N. Grand Blvd., St. Louis, a graduate of the University and Bellevue Hospital Medical College, 1921; member of St. Louis County Medical Society; age 75; died May 8, 1974.

Lee W. Dean, Jr., M.D., 9067 Clayton Rd., St. Louis, a graduate of Washington University, 1933; member of St. Louis County Medical Society; age 67; died May 9, 1974.

Girard A. Munsch, M.D., 19 Berkshire, St. Louis, a graduate of St. Louis University, 1939; member of St. Louis Medical Society; age 60; died May 10, 1974.

Richard W. Denney, M.D., Mountain Grove, a graduate of Chicago College, 1916; member of South Central County Medical Society; age 83; died May 12, 1974.

Roger F. Christensen, M.D., 120 N. "A" St., Louisiana, a graduate of Washington University, 1958; member of Pike County Medical Society; age 40; died May 18, 1974.

Albert Preston, Jr., M.D., 4320 Wornall Rd., Kansas City, a graduate of the University of Pennsylvania, 1937; member Jackson County Medical Society; age 74; died May 20, 1974.

Hugh Ashley, Jr., M.D., P.O. Box 618, Cape Girardeau, a graduate of Washington University, 1943; member of Cape Girardeau County Medical Society; age 55; died June 14, 1974.

Russell C. Porter, M.D., 3744 Atlantic #620, Long Beach, Calif., a graduate of St. Louis University, 1912; member of Clay County Medical Society; age 85; died June 14, 1974.

Elmer G. Graul, M.D., 2838 S. Grand Blvd., St. Louis, a graduate of Washington University, 1935, member of St. Louis Medical Society; age 64; died June 27, 1974.

William V. Koutsoumpas, M.D., 3024 Hawthorne Blvd., St. Louis, a graduate of St. Louis College of Physicians and Surgeons, 1922; member of St. Louis Medical Society; age 82; died July 2, 1974.

IMPROVED ACCIDENT & HEALTH PROGRAMS

The Disability Income Policy sponsored by the Missouri State Medical Association since 1943 has now been made GUARANTEED RENEWABLE and income benefits are available up to $300.00 weekly to members under age 56 subject to acceptance by the Company.

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Council Reports

(Continued from page 479)

Dr. McCanse stated that he would report for Dr. Noback and the University of Missouri Kansas City School of Medicine. UMKC has accepted 72 students for next fall. The formal dedication of the UMKC Medical School building will be held on October 27. Dr. McCanse indicated that the Council and Officers will be invited to attend.

REMARKS OF THE DIRECTOR OF THE DIVISION OF HEALTH

Dr. Domke stated that Mr. Lawrence Graham has been appointed by the Governor to serve as the Director of the new Department of Social Services, under which the Division of Health and Board of Health will operate.

Dr. Domke stated that he had previously asked the Council for assistance in regard to a family planning program for the state. A committee chaired by Dr. Hetlage was appointed and had made a report to the Council. Even though some attempt had been made to organize the various family planning programs in the state, it has been decided by HEW that the present system of family planning will continue this year.

Mr. McIntyre stated that he understood that the Board of Health will require that all hospitals join in a uniform hospital admission and discharge system. Dr. Domke had appointed a special committee to study various plans throughout the country and the committee decided on the Iowa method. The Committee will recommend that the name of the patient and the doctor not be revealed except by individual hospital code and with this code to remain confidential.

The Committee reports that this system will request each hospital to forward 15 various items of information. The Committee further submits the following recommendations:

1. It is strongly recommended that the Missouri State Medical Association ask the Department of Health for a copy of this committee's recommendations.
2. It also recommends that the Missouri State Medical Association get adequate representation on the committee and future committees that may be set up to study this situation.

Dr. Domke stated that he had no objections to the two recommendations. This system is necessary as a means of getting adequate information about the use of hospitals. The Division has operated a program for about ten years, but has not been able to get 100% participation.

Dr. Hetlage moved that the two recommendations mentioned above be adopted. Motion was seconded and carried.

REPORT ON STATEWIDE HEALTH MANPOWER CONFERENCE

Dr. Bradshaw stated that the MSMA had been well represented at the Conference held in Jefferson City on April 22-23. Governor Bond and several speakers occupied the first morning. In the afternoon, the group broke into workshops covering topics such as family practice, long range planning, nursing, allied health, physician assistant, dentists assistants and educational coordination. Each workshop reported back on the second day.

Dr. Bradshaw stated that he chaired the family practice workshop and that group made the following recommendations:

1. The developing data collection study on physician manpower created by the Division of Health and by Dr. Hobbs' group at the University of Missouri is to be strongly endorsed and urged to develop ongoing data collection studies which can provide reliable documentation of trends in health manpower.
2. The group endorses the current cooperative efforts of the Division of Health, the Comprehensive Health Planning Agency, the Missouri State Medical Association, the Missouri Osteopathic Association, the Missouri Hospital Association and the Missouri Academy of Family Physicians in appointing an ad hoc committee to make specific recommendations concerning family physicians for Missouri.
3. The group recognized that it addressed only one component of a much larger issue of health manpower for Missouri and recommended that comparable efforts be undertaken to look at manpower needs in other health fields.

Dr. Bradshaw stated that a special committee is being set up under the leadership of the State Board of Health to help solve the problem of physician manpower in family practice in the state of Missouri.

PSRO

Dr. Chandler introduced Mr. Sam Wheeler, PSRO consultant for the Region VII Office of HEW in Kansas City. Mr. Wheeler stated that the quality of medical care in this country is uneven and, in some instances, far below what the majority of physicians recognize as appropriate.

PSROs will be controlled by the medical profession; standards of care will be developed by those in the profession; the work of a physician will be reviewed only by physicians; any action against an individual to improve the quality of his work will have to be taken by the profession itself and there is an extensive appeals process.

Mr. Wheeler reported that many contract applications for PSROs were received by May 1. Total contracts received nationally were 107 and contracts for ten statewide support centers also were received. Missouri was divided into five PSRO areas and the Missouri Health Care Foundation has submitted an application for a statewide support center. The statewide support center would provide technical support to the five local PSROs. It will not run local PSROs and will come in only if a local PSRO asks for help. He pointed out that specialty societies were working on criteria for use by PSROs. Mr. Wheeler stated that many physicians still have little or no understanding of PSROs. Purposes of the PSRO program are to (1) Have the medical profession develop appropriate standards of care; (2) Insure the same professional conduct and delivery of care throughout the country; (3) If standards are not adhered to, find out why and if necessary take corrective actions. The appeal mechanism starts at the local PSRO Board, then goes to the state PSRO council, the National PSRO council, the Secretary of HEW and then to the courts.

Mr. Wheeler stated that repeal of the PSRO law in his

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opinion will not happen without there being another system to replace it. The answer is not in repeal, but in sensible modification where it is appropriate.

Mr. Wheeler stated that strong regulations in regard to confidentiality of records had been built into the law. He indicated that PSRO could be a protective shield against malpractice because of agreement on professional standards. Establishing such standards regionally in the country could help free physicians from malpractice. The PSRO program was set up as a quality improvement program, but it is believed that cost reduction will be the result.

Dr. Hetlage stated that several states had taken a nonparticipation attitude in regard to PSRO and asked what would happen in these instances. Mr. Wheeler stated if no PSRO mechanism has been set up by January of 1976, the Secretary of HEW would pick out an appropriate institution, agency or group in the area to do the job. Mr. Wheeler outlined several types of review that will be done. A question was asked as to what it is costing to manage the PSRO program.

Mr. Wheeler stated that this year, the cost is about $30 million and is expected to go up to $55 million next year. A question was asked as to how it would be decided what would be an appropriate fee for physicians doing review. Mr. Wheeler stated that this wouldn't be decided until a norm has been established. Mr. Wheeler pointed out that the program was four to six months behind schedule.

REPORT OF THE COMMITTEE ON LEGISLATIVE AFFAIRS

Dr. Matthews stated that the following bills supported by MSMA had been passed during the last session of the General Assembly:

A "Sick Doctor" bill, which has been signed by the Governor. This provides that the Board of Healing Arts can require a "sick" physician to meet certain criteria to continue to practice. The bill is designed to protect the public and to salvage "sick" physicians.

Insurance for Newborn was approved, but has not been signed as yet by the Governor. This bill provides that all individual and group health insurance policies would automatically afford coverage for newborn children of the insured from moment of birth.

The physical therapists licensure bill has been signed by the Governor. This law strengthens the present law by prohibiting a person not licensed as a physical therapist from representing himself as a physical therapist.

The Governor's bill on high-risk maternity and prenatal care was combined with a state aid for public hospitals bill and passed. It has not been signed as yet. The bill provides state aid to public hospitals. The bill also provides for a program of care for women who have a high risk of developing conditions leading to premature births or who might produce mentally retarded children. Program includes diagnostic and treatment centers for such women.

Other bills of interest considered during the last Session are as follows:

An abortion bill was passed, but has not yet been signed. The bill provides that no abortion could be performed in the first 12 weeks except by a licensed physician with the consent of the woman, her spouse or a parent if she is under 18 and unmarried. Abortions after the first 12 weeks must meet the same criteria and be performed in a hospital.

"Patients Rights" bill was passed. It prohibits the use of or participation of inmates or patients of state correctional, mental or other institutions in clinical research projects without the informed consent of the patients or inmates or certain relatives or guardians. Depending on the nature of the research, the approval of the Division of Health or Division of Mental Health also might be required. This bill has not been signed.

Several bills calling for the repeal of the 1973 ambulance law were not passed. An acupuncture bill and a bill that would have greatly expanded crippled children services were not passed. A bill calling for the removal of the words "by hand" from the chiropractic practice act and a physical therapy bill which would have opened the practice of physical therapy to chiropractors also were not passed.

Dr. Matthews stated that a $50,000 planning bill for an optometry school located in St. Louis was passed and signed by the Governor.

Dr. Domke stated that under state reorganization, the Board of Health and the Division of Health would be a part of the new Department of Social Services as of July 1.

Dr. Matthews also reported that the following bills of interest were not passed: Delegation Amendment; Insurance for Psychiatric Care; Mandatory Seat Belt Usage; Use of Generic Name of Drugs on Prescriptions; Treatment of and Insurance for Alcoholism; and a bill to regulate and license Clinical Laboratories.

Legislative matters proposed by the House of Delegates for 1975 include support for seat belt usage, support for insurance for mental illness and support for complete maternity coverage insurance.

Dr. Matthews stated that an Interim Committee of the Missouri House and Senate has been established to consider, investigate and study the areas of physician assistants, medical laboratories, acupuncturists, surgi-centers and other related matters in respect to the possible need for licensure and regulatory legislation. Dr. Matthews asked Council approval for the President to be empowered to appoint ad hoc committees in each of the above mentioned areas so that we may be prepared to present proposals in these areas when asked to do so by the Interim Committee.

A motion was made, seconded and carried that such ad hoc committees be appointed in the areas of physician assistants, medical laboratories, acupuncturists and surgi-centers.

Dr. Matthews expressed his thanks to Messrs. Royal O. Cooper, Cork Swarens and Ray McIntyre for their assistance during the Legislative Session. Dr. Matthews stated that we had gotten 80% of our total program through the Legislature and that this is quite an accomplishment.

PRACTICE MANAGEMENT WORKSHOP

Mr. Swarens reported that the Practice Management Workshop was held in St. Louis on May 6 and 7. This workshop provides information on establishing yourself in medical practice. Eighteen people attended and expressed extreme pleasure with the information provided. Mr. Swarens stated that the AMA is going to reassess this program to see if it can sponsor more of these later and, perhaps, we should consider having another one if they are again offered. Mr. McIntyre indicated that he would like to commend St. Louis Medical Society for their assistance in handling this workshop.

REMARKS OF THE SPEAKER OF THE HOUSE OF DELEGATES

Dr. Slickman stated that there was general agreement that the sessions of the House of Delegates went extremely well this year and that he could not foresee any changes next year. He did indicate that the reference committees might meet a little earlier on the first day. Dr. Chandler stated that he would like to commend the Speaker for a job well done.

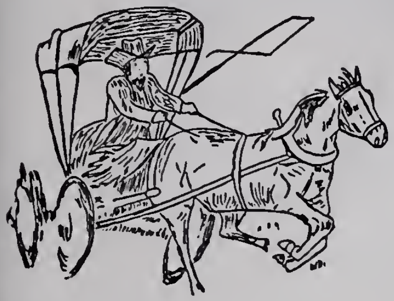
NEXT COUNCIL MEETING

Dr. Chandler stated that the next meeting is tentatively scheduled for the middle of September at the Alameda Plaza in Kansas City.

The meeting was adjourned.

LEO H. POLLOCK, M.D.

Missouri Medicine in Review



FORTY YEARS AGO

Dr. Edwin Lee Miller, Kansas City, was chosen President-Elect of the Missouri State Medical Association by the House of Delegates at the Annual Session held in St. Joseph on May 7-10. Dr. Miller will serve as President-Elect in 1934-1935 and as President in 1935-1936. He received his degree in medicine from the Harvard Medical School in 1911 and attended foreign clinics during the following six months.

In recognition of his services in editing "The History of Urology," Dr. Bransford Lewis of St. Louis received a bronze plaque at the annual banquet of the American Urological Association in session at Atlantic City. During the presentation, an orchestra played "Moonlight and Roses." The musical selection was prompted by an article written by Dr. Lewis and Dr. Grayson Carroll entitled "Prostatic Resection Without Moonlight and Roses."

Hospitalization to Veterans: After the passage of the National Recovery Act approved on March 20, 1933, treatment and hospitalization of veterans was limited to those suffering from diseases and injuries incurred or aggravated in line of duty in active military or naval service and veterans without means of support and incapacitated from earning a living, suffering from permanent disabilities or tuberculosis or neuropsychiatric ailments.

TWENTY-FIVE YEARS AGO

On Dec. 31, 1948, the official membership of the Missouri State Medical Association was 3,478. There was a net gain of 94 members from Dec. 31, 1947. Of this number, 334 were Honor members.

The following honor members are eligible for Affiliate Fellowship in the American Medical Association: Drs. Peter T. Bohan, Kansas City; Jonathan E. Burns, Charles Town, W. Va.; F. A. Carmichael, Kansas City; Paul F. Cole, Springfield; Clyde P. Dyer, Webster Groves; John D. Hayward, St. Louis; Joseph D. James, Springfield; Frederick C. Lamar, Kansas City; A. Edward Meisenbach, St. Louis; W. A. Myers, Kansas City; Thomas M. Paul, St. Joseph; Abram T. Quinn, St. Louis; Hudson Talbott, St. Louis; James A. Townsend, Eureka; and Arthur W. Westrup, Webster Groves.

The total number of persons enrolled in Blue Cross plans as of Dec. 31, 1948 was 1,128,550. The population of the state in the census of 1940 was 3,700,000. Thus, about 30% of the population was covered by Blue Cross Hospital Service. The total number of persons enrolled in Blue Cross medical and surgical care plans as of Dec. 31, 1948 was 359,333, representing about 10% of the state's population.

The MSMA urges communities throughout the state to avail themselves of the grants offered under the Hill-Burton Act in meeting the need for hospital beds in rural areas. During 1948, a total of $2,282,550 in federal money was made available in Missouri for the improvement and construction of hospital units. United community action of all groups is necessary to solve the hospital bed shortage in rural areas. The task of meeting the requirements of the provisions under the Hill-Burton grant is a local one, and the Missouri State Medical Association offers its support to communities in working out plans.

TEN YEARS AGO

On Dec. 31, 1963, the official membership of the Missouri State Medical Association was 3,874.

The hyphenation of Perry County and Ste. Genevieve counties was approved by the Mineral Area and Perry County medical societies and by physicians in Ste. Genevieve County.

An average of more than $1 million a month was paid in medical-surgical benefits by the St. Louis Blue Shield Plan during the fiscal year ending on April 30, it was announced at the 19th Annual Meeting of the Blue Shield voting board in St. Louis on June 28. Dr. R. O. Muether, president of St. Louis Blue Shield, reported that a total of $12,181,309 was distributed in benefits during the year.

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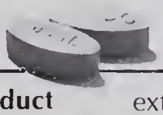

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SEPTEMBER, 1974
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117th MSMA Annual Session
April 17-20, 1975, St. Louis

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequ
and/or severity of grand mal seizures a
require increased dosage of standard a
convulsant medication; abrupt withdra
may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous
gestion of alcohol and other CNS depre
sants. Withdrawal symptoms (similar t
those with barbiturates and alcohol) h
occurred following abrupt discontinua
(convulsions, tremor, abdominal and m
cle cramps, vomiting and sweating). K
addiction-prone individuals under care

respond to one

According to her major nptoms, she is a psychoneuic patient with severe xiety. But according to the scription she gives of her lings, part of the problem y sound like depression. is is because her problem, hough primarily one of exsive anxiety, is often accomnied by depressive symptomlogy. Valium (diazepam) provide relief for both—as excessive anxiety is reved, the depressive sympns associated with it are also en relieved.

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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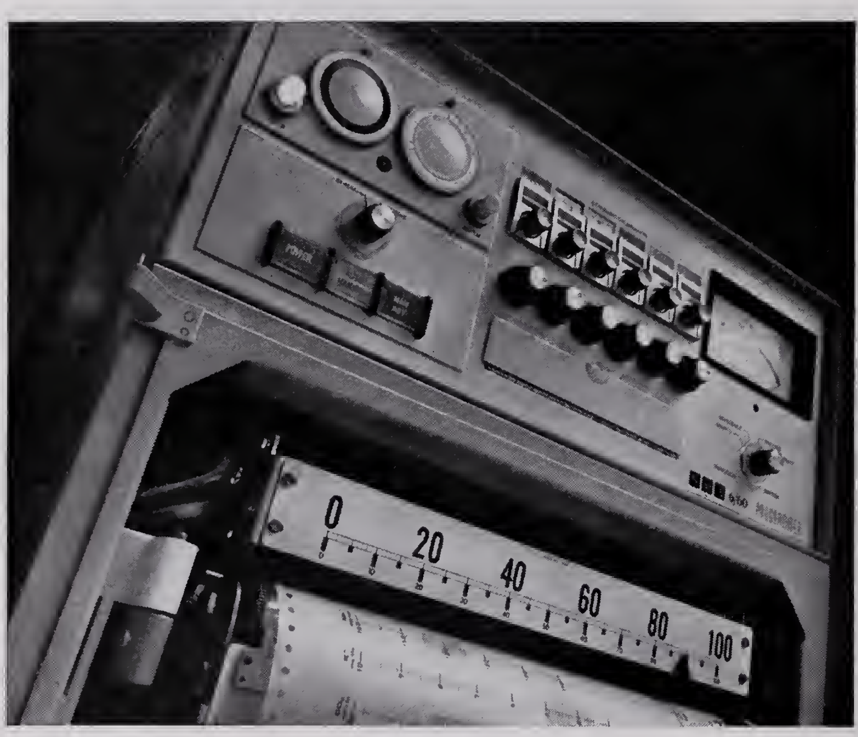

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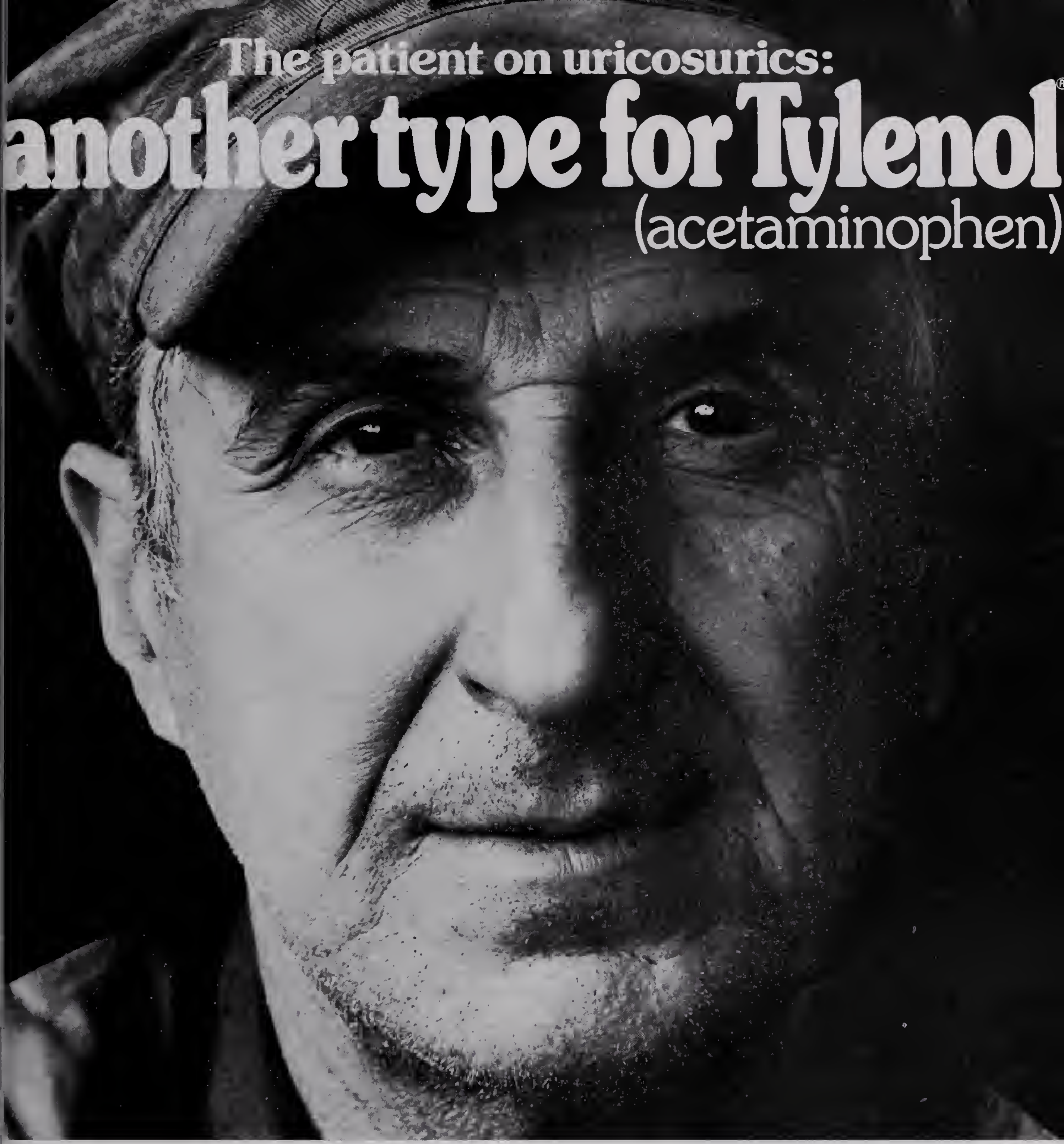
The patient on uricosurics: another type for Tylenol® (acetaminophen)



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References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

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MSMA NEWS ROUND-UP

September, 1974

Voters abolish coroner's office

Four counties adopt Medical Examiner System

Four Missouri counties overwhelmingly adopted the County Medical Examiner System in the August 6 elections.

The new system will replace the coroner system in the counties of Boone, Buchanan, Callaway and Cole.

Missouri counties are allowed to replace the coroner system with the medical examiner due to a bill passed by the 1973 Missouri General Assembly. The measure was heavily supported by the MSMA. When the law went into effect, Greene and Clay counties automatically switched to the examiner system.

Under the law, the examiner **must** be a physician. The law gives examiners increased responsibility in determining the cause of deaths which occur under violent or suspicious circumstances. It has been hailed by many as a step forward in modern law enforcement.

Following passage of the law last year, John I. Matthews, M.D., chairman of the MSMA Legislative Committee, called on local Medical Societies to lead the drive for implementing the examiner system.

Responding to the request, the Medical Societies in the Boone, Buchanan, Callaway and Cole requested their respective County Courts to place the issue on the ballot. The issue required a simple majority to pass. Currently, Callaway and Boone Counties are working on a plan to combine the services of one medical examiner to serve both counties, which is allowed under the law.

County Societies or individual physicians interested in leading the way for the establishment of a medical examiner system in their area can contact the MSMA Headquarters for further information.

Auditor says FLEX test violates Missouri laws

The Board of Registration for the Healing Arts will meet Sept. 28, to consider a report of the State Auditor which contends the FLEX examination does not meet requirements of state law.

In June 1972, the Board dropped a two-part test and adopted the three-part FLEX examination developed by the Federation of State Medical Boards.

State Auditor John D. Ashcroft said in his report that the findings did not mean the doctors who took the FLEX exam were not competent.

"We are only stating that these doctors did not pass an examination whose grading met the requirements of state law," Ashcroft said.

Missouri law states a candidate for licensing must score at least 75 percent on each of two parts of a standardized test. In addition, a candidate must score at least 60 percent on each subject matter area within the two-part test.

FLEX scoring is computed for the entire examination and does not include part or subject score, Ashcroft asserted, and "it is not possible to determine whether any of the 452 doctors licensed between June of 1972 and December of 1973 meet legal requirements."

John A. Hailey, executive secretary of the healing arts board, said the FLEX exam "is more difficult than the old one and is by far the best ever devised for the licensing of physicians."

Hailey said the test is used by 48 of the 50 states.

"If this test was illegal for us, it would be illegal for us to accept reciprocity licensing for many physicians who move into Missouri each year from other states," said Hailey.

He said the FLEX test reflects the increasing sophistication of modern medicine where subject matter overlaps and where, for example, knowledge of anatomy might be necessary to answer a question on biochemistry. The old test did not allow for the explosion of medical knowledge experienced the last two decades, asserted Hailey.

Ashcroft said that facts support the board's assertions that high standards are being maintained in licensing of physicians. However, he said, "they do not justify circumventing the apparent intent of state law."

He recommended that the board comply with present law until the legislature deletes the inflexible requirements.

Haily agreed that the law involved probably should be changed.

Darling Decision 'often erroneously interpretated'

A spokesman for the American Hospital Association, testifying before a Reference Committee at the AMA 1974 Annual Session, said the AHA would be willing to work with the AMA in clarifying erroneous interpretation of the "Darling Decision".

The MSMA House of Delegates had earlier directed that Missouri physicians be informed as to the actual ramifications of the "Darling Decision". The MSMA resolution regarding the subject has been published in MISSOURI MEDICINE.

Several attempts by hospital administrators and boards to apply the Darling Decision strictly and thereby usurp traditional powers from hospital medical staffs led to the introduction of several AMA resolutions.

Reference Committee discussion was lengthy and pointed out that certain hospitals were, indeed, placing more importance on the Darling case than it deserved. The Reference Committee therefore recommended adoption of Resolution 82.

The following is an excerpt of the Resolution passed by the AMA House:

"One of the most misunderstood court decisions in recent years has been the Darling case. Though our Legal Department has repeatedly brought out that it has a much more narrow application and construction than is generally believed, it has assumed a greater importance than it merits, expecially among hospital administrators, governing boards and their attorneys.

"Betty Anderson, J. D., of the AMA Office of the General Counsel, states: 'The developing trend on the part of some hospital governing boards to attempt to exercise direction and supervision over staff physicians in reliance on the Darling case is widespread enough to be of great concern. In some of these hospitals, such control is exercised by the governing board's appointing salaried department heads, salaried chiefs of staff and a medical staff executive committee of salaried physicians. The members of the attending staff then become subject to the direction of the salaried physicians. Under these circumstances, the medical staff is not self-governing and has no separate existence as a deliberative medical body.

" 'The reported cases in the various states following Darling either have rejected the case as a precedent or have followed it as precedent for hospital liability for employee negligence.

" 'Some hospital consultants, hospital administrators and their attorneys have spread an erroneous interpretation of the Darling case with such frequency that there seems to be a generally held opinion that the misinterpretation accurately reflects the law of the land. Nothing could be further from the truth. In the nine years since the Darling case was first tried, it has either been entirely rejected by other courts or narrowly construed'. "

"It would seem that more is necessary than articles and talks by our Legal Department. It would seem that minimally the facts and implications of the case be recognized by this House for dissemination throughout the profession and hospitals. Therefore be it

"**Resolved**, That the Board of Trustees set up a liaison among those parties involved (The American Hospital Association and/or the Joint Commission on Accreditation of Hospitals and the American Medical Association) so that the decision of the Darling case may be clarified, and that the erroneous interpretations that have been put on it may be corrected, and that a joint statement, complete and thorough, be jointly formulated for distribution to all involved — including minimally hospital administrators, lay hospital boards, hospital attorneys, and county and state medical societies."

Major Hospital-Nurse insurance still available

A story in the July issue of MISSOURI MEDICINE which announced a $100,000 Major Medical insurance program to be offered to MSMA members soon, inadvertently stated that the program replaces the current MSMA-sponsored Major Hospital-Nurse Expense Program.

The Major Hospital-Nurse Expense Program, which has been administered by Eggert-Carroll-Schroeder Agency, Inc., of St. Louis, and the Altman-Singleton and Co., of Kansas City, for more than 15 years, continues to have sponsorship of our Association.

As stated in the earlier story, those members who currently have the Major Hospital-Nurse Expense policy may keep it if they desire.

Medical surveys planned in West Missouri counties

The Health Examination Survey of the U.S. Public Health Service will begin conducting surveys in the counties of Cass, Clay, Jackson and Platte during September.

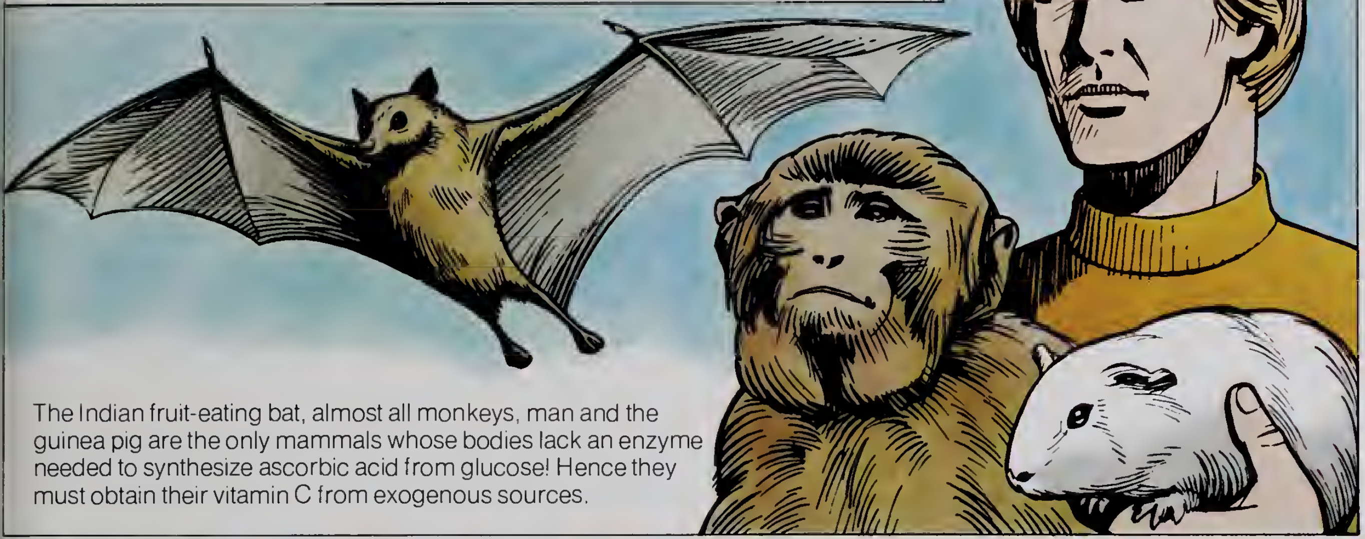
The initial phase will begin Sept. 23 with interviewers from the U.S. Bureau of Census calling on selected households in the counties to obtain information and select about 120 persons for the examination.

Examinations will be conducted from Oct. 5 through Oct. 23, 1974, in the survey's mobile examination center.

The information gathered is used by federal, state and local health agencies, researchers, educators and many other public and private agencies.

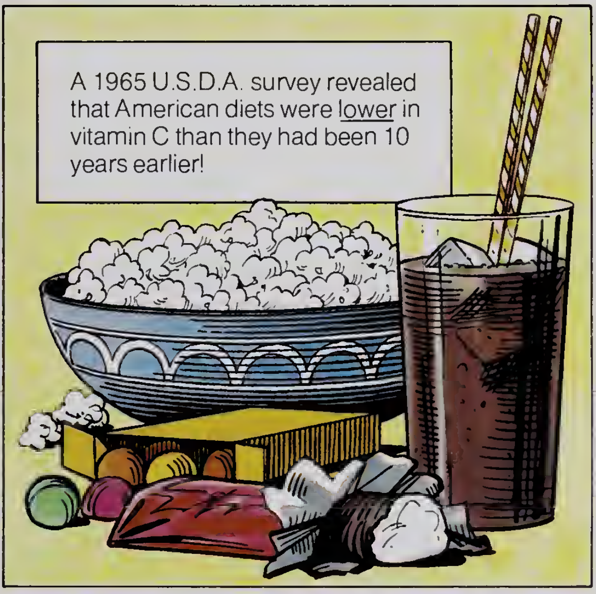
No treatments or medical advice are given to those examined.

The ALLBEE® with C Scrapbook
of Vitamin Facts & Fallacies



The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!

The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

Available on your prescription or recommendation

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	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
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hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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THOMAS B. HALL, JR., M.D., ***Arrow Rock***

Eupatorium perfoliatum

A Plant With a History

Eupatorium perfoliatum (Boneset, Thoroughwort) is described by Joan Parry Dutton in *The Flower World of Williamsburg* as "Boneset, that cure-all of yesterday's ills when in every knowing farmhouse it was brewed into boneset tea."

Boneset is said to have been introduced to the American colonists by the Indians for the treatment of the very common disease, the ague (malaria). The violent rigors of malaria shook the bed, caused the patient's teeth to chatter and even separated weak bones. The ability of this plant to control the violent chills of malaria is probably responsible for the name, boneset. It was known to the Indians as the ague weed.

The introduction to the colonists of this plant by the Indians certainly bore fruit. There is no doubt that for centuries among the public, this plant was a popular remedy for malaria, which was widespread in America.

Jesuit or Peruvian bark was introduced into Europe in 1630. The bark contained the invaluable quinine, but in a very impure form (2%-4%). Its irritating cortical properties and difficult and time-consuming preparation were drawbacks to its use. While cinchona bark was generally accepted by the medical profession, most of the people stuck to boneset, a widely distributed and common plant. The fact that the medical profession generally did not rely on the bark alone but combined its use with severe catharsis, bleeding and emesis did not favor its acceptance by the public.

In 1820, a great advance in the treatment of malaria was made by the isolation of quinine from the Peruvian bark. In 1823, the first manufacture of quinine on a small scale was begun in Philadelphia.

In 1824, Dr. John Sappington of quinine fame rode from Saline County, Missouri and bought all the quinine available in Philadelphia, bringing it back in his saddle bags. The introduction of quinine into a wide area favored a decrease in the use of boneset. However, the indications are that the public was slow to abandon it.

In his *Theory and Treatment of Fevers* (1844), Dr. John Sappington states that boneset and Culver's root are the best indigenous substitutes available for quinine. Quinine at times became unavailable or in short supply in the malarious districts.

Boneset, escaped from herb garden of the Thornton Homestead, two miles north of Arrow Rock, settled in 1816.

The physicians and pharmacists evidently had a serious interest in eupatorium. Dorland's Medical Dictionary (1941) lists eupatorium as "a precipitate derived from *Eupatorium perfoliatum;* diaphoretic, aperient, tonic and stomachic."

The superiority and availability of quinine and the gradual disappearance of malaria in America (indigenous malaria is extinct at present in the

---

Dr. Hall is the Friends of Arrow Rock chairman for the planning and building of the Dr. John Sappington Memorial Building. He is the author of *Medicine on the Santa Fe Trail* (1972) and donated the proceeds from the sale of this book toward the construction of the building, which was completed this year and dedicated on June 19, 1974.

U.S.A.) were factors in the abandonment of boneset in America. The references in the current literature and inclusion in a government bulletin indicate that the once widely popular boneset has not been entirely forgotten.

Eupatorium perfoliatum has greyish white flowers which appear in July and August and persist to frost. The leaves arise from around the stem. It is not readily eaten by cattle. This probably accounts for its great prevalence in some pastures in Missouri.

Boneset was a widespread plant in the eastern United States which many of our ancestors knew and held in high repute. Wise's *Garden Encyclopedia* (1935) states that *Eupatorium perfoliatum* is often seen in our gardens. Its persistence and profusion around old homesites, such as at the Thornton home on the Missouri River above Arrow Rock (1816) after generations of the Thorntons have gone, indicates the high repute in which our remote ancestors held this hardy herb.

Reprints: Thomas B. Hall, M.D.
Arrow Rock, Mo. 65320

Weekend Program Scheduled for November 22-23 at UM-KC

The Nov. 22-23, 1974 Long Weekend program sponsored by the School of Medicine and the Division for Continuing Education of the University of Missouri-Kansas City, Kansas City Southwest Clinical Society and the Academy of Health Professions will cover the subjects of neurology and psychiatry. The meeting will be held at the Crown Center Hotel and the new University of Missouri-Kansas City School of Medicine in Kansas City.

The Long Weekend programs are accredited for 13 credit hours in Category I for the Physician's Recognition Award of the American Medical Association and 13 prescribed hours by the American Academy of Family Physicians.

These workshop sessions are designed to provide the practitioner with solid clinical knowledge useful in the practice of medicine. The format stresses involvement and participation by case presentations, practical demonstrations and in depth discussions. Recognizing that the practicing physician has a continual need to upgrade his information base regarding disease management, therapeutics—especially the "how" of management—is emphasized.

These postgraduate sessions are limited to 40 physicians and spouses. For complete program and registration information, contact The Long Weekend, University of Missouri-Kansas City School of Medicine, 2220 Holmes St., Kansas City, Mo. 64108 or phone 816/471-3876.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

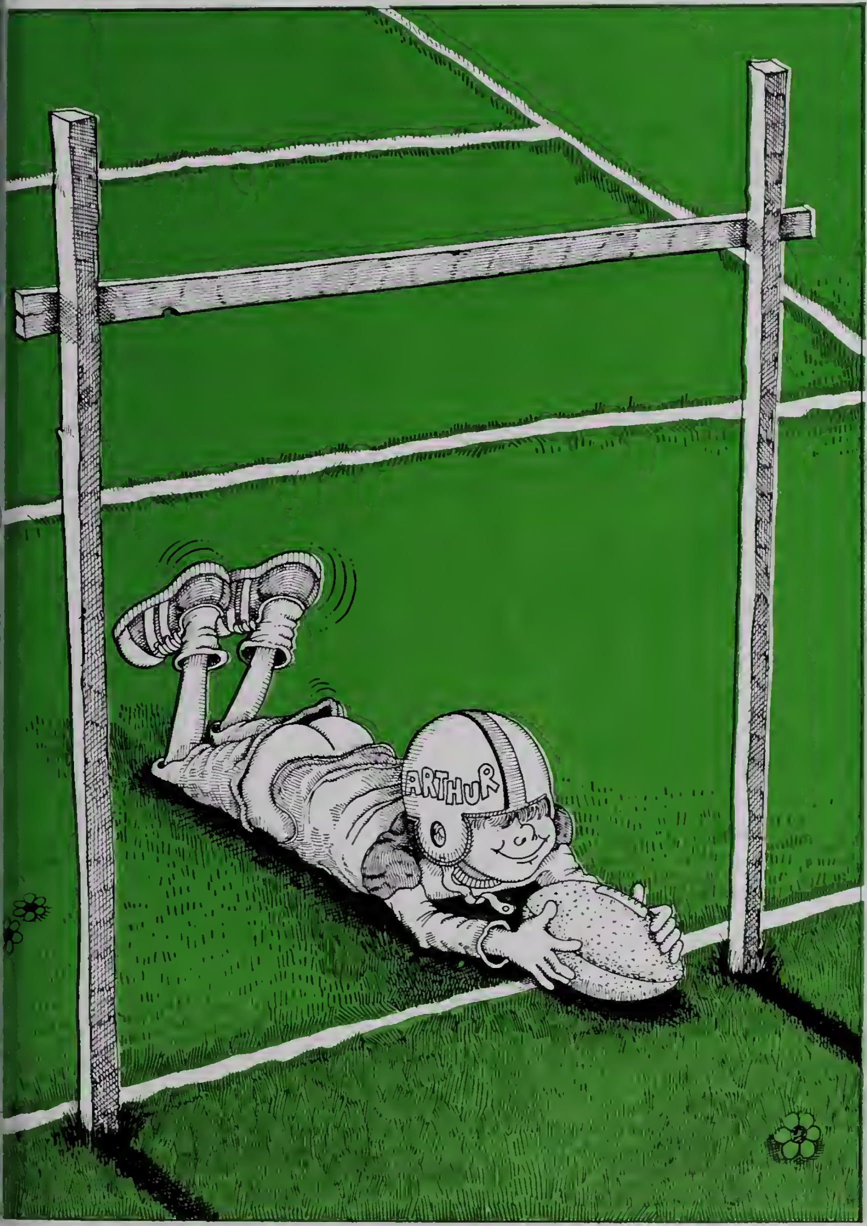
CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



WORMS BLITZED

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

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Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

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Please see prescribing information on facing page.

WASHINGTON

The House's Interstate and Foreign Commerce subcommittee on health has crushed by an eight to one vote a public utility-like plan that would control physician fees and hospital charges, a provision regarded by many as the most threatening health measure on Capitol Hill.

The vote appeared to assure the doom of the public utility concept both in the full House Commerce Committee and the House. There remains the possibility of Senate approval, however.

The controversial provision is part of a comprehensive and complicated rewriting of the Comprehensive Health Planning and Regional Medical Programs of the federal government. The proposed strict rate controls exercised by the states are backed by Sen. Edward Kennedy (D-Mass.) and Rep. William Roy (D-Kans.), the latter a physician who cast the lone vote for the provision in the House subcommittee.

Opponents of the plan were subcommittee Chairman Paul Rogers (D-Fla.) and Democratic Reps. David Satterfield (Va.), Peter Kyros (Maine), L. Richardson Preyer (N. C.); and GOP Reps. Ancher Nelson (Minn.), Tim Lee Carter (Ky.), James Hastings (N. Y.) and H. John Heinz, III (Pa.). Absent but favoring the majority position were Reps. William Hudnut (Ind.) and James Symington (Mo.).

The vote was on a motion to strike from the bill language that would have authorized federal funding for State Health Commission programs of regulating charges in the medical field with ultimate authority in the HEW Department.

Health providers have opposed the plan. Declaring that the legislation has "far reaching implications for the future of delivery of health care services," Richard Palmer, M.D., chairman of the American Medical Association's Board of Trustees, told the subcommittee earlier this year that under the disputed plan "the health sector in effect would be deemed to be one vast, monolithic public utility."

Dr. Palmer said, "We must caution against the imposition of a massive bureaucratic control of the health care system . . . the economic forces inherent in this proposal could defeat the intention of this Committee to foster the development of improvements in our health care delivery system."

The subcommittee adopted a requirement that the local planning agencies monitor individual institutional rates within the state and publicly comment on such rates.

Also included in the subcommittee draft are provisions to require states to have Certificate of Need legislation or similar legislation relating to the construction of new facilities.

States would be required within three years to review and comment on the need for all facilities and services provided within the state.

* * *

The American Medical Association has joined with the Association of American Medical Colleges in opposing the Administration's proposal to cut back on federal aid to medical education.

The Senate Health subcommittee was told by the AMA that "it seems particularly inadvisable to reduce support to institutions with national health insurance now being considered in the Congress."

"Moreover, any shift away from institutional support by requiring students or their families to provide the major portion of education costs through loans or service scholarships may prevent some able students from families with low incomes from contemplating or entering a health profession," the AMA said in a statement submitted to the subcommittee.

"This is not the time," the AMA statement said, "to make sudden shifts in federal policies and to create uncertainty and instability in educational or health care institutions."

At the same time, the AMA opposed a provision of a bill prepared by subcommittee Chairman Edward Kennedy (D-Mass.) that would require all medical school graduates to serve in shortage areas for two years. "These draft-like provisions would be unique to the health professions, would constitute a dangerous precedent and would be contrary to fundamental concepts of the American educational system," said the statement.

Instead, the AMA fully backed provisions to increase support to the National Health Service Program for placing Public Health Service physicians and health personnel in shortage areas for two years.

medical melange

Notes of interest from Here . . . . and There

Dr. Robert Hudson of the Kansas University Medical Center was the guest speaker at the June 16 dedication of the **Doctor John A. Sappington Building** in Arrow Rock by the **Friends of Arrow Rock**, a not-for-profit group of citizens organized to preserve history, restore old buildings and collect artifacts for posterity. The building was constructed as a living memorial to Dr. John Sappington, a pioneer Missouri Doctor in the 19th century.

Dr. Ned D. Rodes, a practicing surgeon in Mexico for 15 years and chief surgeon at Ellis Fischel State Cancer Hospital in Columbia from 1955 to 1958, has been named project director of the Cancer Research Center's breast cancer detection demonstration project in Columbia. The facility, which became fully operational on July 1, is one of 27 in the United States and is jointly funded by the National Cancer Institute and the American Cancer Society.

Dr. Henry E. Oppenheimer, Clayton, attended the annual meeting of the American Diabetes Association in Atlanta, Ga. in June. Dr. Oppenheimer was reappointed chairman of the Committee on Advertising and to the Editorial Board of the journal, *Forecast.*

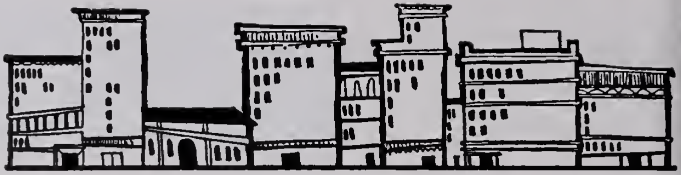
Dr. Howard W. Carrington has been elected to the Board of Trustees of Wallace-Rowden Hospital in Lebanon to fill the vacancy created by the resignation of Mr. David Donnelly. Dr. Carrington has practiced medicine in Lebanon for 28 years. He is the first physician to serve on the hospital Board of Trustees since 1956.

Dr. E. L. Niedermeyer of Tarkio has received a special plaque recognizing his 25 years of service to residents of Atchison County as a physician on the staff of Community Hospital in Fairfax. The presentation was made at a recognition dinner on July 9 in Tarkio. Dr. Niedermeyer is the only member of the original medical staff who still lives in that area.

Dr. John D. Arnold, Kansas City, was elected the 1974-1975 president and **Dr. Clifford R. Talbert, Jr.**, Cape Girardeau, was elected president-elect of the Missouri Heart Association at the annual meeting dinner held in Columbia. Dr. Arnold also is president of the Kansas City Heart Association.

Dr. E. O. Shelton, Eldon, has retired after practicing medicine in the Eldon community for more than 40 years. Dr. and Mrs. Shelton will continue to live in Eldon.

From the Medical Schools



WASHINGTON UNIVERSITY

A $133,533 grant for cancer diagnostic research has been received by a Washington University School of Medicine scientist.

C. Elliott Bell, Jr., M.D., assistant professor of pathology and medicine, was awarded the funds by the National Cancer Institute.

The three-year grant will be used to study "Antigens and Immunity in Human Bronchogenic Carcinoma." Dr. Bell will seek to identify an antigen on the surface of lung cancer cells which is absent from normal lung cells.

Two School of Medicine researchers have been awarded National Foundation-March of Dimes grants totaling $85,400.

David Apirion, Ph.D., associate professor of microbiology, received $45,400, and *Jack R. Lichtenstein*, M.D., assistant professor of medicine, was awarded $40,000. Both are two-year grants.

Dr. Apirion is seeking to develop ways to make test-tube grown cells produce proteins normally not found in such cells, but in various body tissues.

Dr. Lichtenstein will use his grant for research to identify basic inborn defects responsible for osteogenesis imperfecta (OI).

The Brown-Hazen Program of the Research Corporation of America, Minneapolis, Minn., has renewed a $36,500 grant for graduate research and training in medical mycology at the School of Medicine.

Three postdoctoral fellows doing research and clinical investigation in the study of fungi are supported by the program. All are preparing for academic careers.

George S. Kobayashi, Ph.D., and *Gerald Medoff*, M.D., both asociate professors of medicine and assistant professors of microbiology, are coordinating the program.

A Washington University otolaryngologist has received $50,791 to coordinate the planning of a national cooperative study for diagnosis and treatment of head and neck cancers.

Dr. Joseph H. Ogura, Lindburg Professor and head of the Department of Otolaryngology, received the grant from the National Cancer Institute.

The grant will fund a series of meetings of 17 of the nation's most prominent otolaryngologists, pathologists, radiologists and plastic and general surgeons. Authorities from other medical specialties will be called as consultants.

UNIVERSITY OF MISSOURI-COLUMBIA

Chancellor Herbert W. Schooling announced on July 12 that *Dr. William D. Mayer* had requested that he be relieved of his duties and obligations as dean of the School of Medicine at the University of Missouri-Columbia effective Sept. 1, 1974 and that he return to the Department of Pathology as a faculty member.

In accepting the resignation, Schooling said, "I appreciate the leadership Dr. Mayer has provided and can think of no one connected with the University who has been more dedicated to its welfare and has given more of himself in its behalf."

He added, "During the seven years Dr. Mayer has served as dean, we have made much progress in the development of the medical school and I give him full credit for the aggressive way in which he kept the needs of the medical center before us."

Included in that progress, Schooling noted, has been the construction and opening of the Veterans Administration Hospital as an integral part of the academic, research and service programs of the Center and the addition and renovation of McHaney Hall to become the Howard A. Rusk Rehabilitation Center.

During Mayer's tenure, the Arthritis Center was established as a regional resource. Other accomplishments were the opening of the Clinical Research Center; the establishment of the renal dialysis and renal transplantation programs; the development of the Family Medicine and Primary Care Program; the initiation of the Cardiac Intensive Care Unit; and the development of the Emergency Medical Services program which has since trained well over 1,000 individuals throughout the state.

Under Dean Mayer's leadership the annual operating funds for research and training coming from sources outside the University have more than doubled going from $2.8 million in 1967 to more than $6 million in the 1973-1974 academic year.

The Chancellor said that the average duration in office of medical school deans across the country was five years and that Dean Mayer had already served in the difficult role two years longer than the average.

Schooling has asked *Dr. Joseph M. White,* provost for health affairs at UMC, to serve as interim dean until a new dean is appointed. White also will have the responsibility of consulting with the medical school faculty and to determine the process by which the new dean will be selected. Schooling said it also will afford Dr. White, who has been at UMC for only one academic year, an opportunity to become familiar with the day-to-day operations of the school of medicine and its personnel.

Dr. Marion S. DeWeese, chairman of the Department of Surgery at the UMC Medical Center for the past ten years, will leave Columbia this week to enter private practice with two colleagues in Ann Arbor, Mich. *Dr. Hugh E. Stephenson Jr.,* professor of surgery at UMC, has been appointed acting chairman of the department.

Medical Center employees honored Dr. and Mrs. DeWeese at a farewell party Friday afternoon. Dr. DeWeese has been honored within the past year by his former resident physicians who trained under him at UMC and the University of Michigan Medical Center. They established the Marion S. DeWeese Surgical Society in recognition of his exceptional qualities as a scholar, surgeon and teacher.

ST. LOUIS UNIVERSITY

St. Louis area physicians were invited to tour the St. Louis University Medical Center's Chronic Hemodialysis and Home Dialysis Training Center at 1320 S. Grand Blvd. on July 14. The unit is the first free-standing kidney unit established in the state of Missouri. The Open House marked the first anniversary of its operation. It is the outpatient division of the St. Louis University Hospitals Renal Dialysis Unit at 1325 S. Grand Blvd.

Dr. Robert E. Cuddihee, Jr., assistant professor of internal medicine and director of the Section of Nephrology at St. Louis University, is director of the Center. He is assisted by *Dr. John E. Codd,* surgeon, *Dr. John G. Gregory,* urologist; and *Dr. Satya J. Sagar,* nephrologist, all of the University Medical Center.

More than 15 patients are receiving dialysis at the Center two or three times a week. A federal program, in effect since last July, covers most patients with chronic kidney failure under Medicare.

Purpose of the establishment of the dialysis unit outside the hospital was to reduce the cost of hemodialysis which can be as high as $30,000 per year when done in a hospital. Significant reduction in the cost of dialysis can be made by performing the treatments outside the hospital since there is not the cost of overhead.

Costs can be even further reduced if the patient and a member of his family can be trained in hemodialysis to be done at home. The Center's training program provides this special service.

The Missouri Regional Medical Program has recently awarded the St. Louis University Hospitals $62,000 for the support of the Center's Chronic Hemodialysis and Home Dialysis Training Center and for the Renal Dialysis Unit within the University Hospitals. The award will supplement Medicare benefits for some renal patients who have accumulated hospital bills they are unable to pay. The grant will reimburse the University Hospitals for those expenses not covered by Medicare.

Dr. Arthur E. Rikli, coordinator of the Missouri Regional Medical Program, announced the award. Efforts of the Missouri Kidney Foundation led to establishment of a state fund to aid kidney disease victims in 1968. The funds are appropriated to the Curators of the University of Missouri. The Missouri Regional Medical Program administers the funds on a no-charge basis, leaving the full amount available to assist victims of kidney disease.

IMPROVED ACCIDENT & HEALTH PROGRAMS

The Disability Income Policy sponsored by the Missouri State Medical Association since 1943 has now been made GUARANTEED RENEWABLE and income benefits are available up to $300.00 weekly to members under age 56 subject to acceptance by the Company.

Also, the Major Hospital and Nurse Expense Program offers higher limits with increased Room & Board Benefits.

For Complete information call or write to:

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in Brief

A summary of AMA, medical & health news

American Medical Association / 535 North Dearborn Street / Chicago, Illinois 60610 / Phone (312) 527-1500 / TWX 910-221-0300

Some conclusions on acupuncture were reached by the AMA's delegation to China after its recent visit. The delegation said that acupuncture analgesia merits controlled experimental study and that clinical studies of its applicability might best be carried out through cooperative ventures between accomplished Chinese practitioners and licensed American physicians, dentists and research scientists. Acupuncture therapy should be regarded as the practice of medicine in an experimental phase, permissible only in qualified investigational settings, the delegation said. It added that every effort should be made to guard against the conversion of acupuncture into a new kind of quackery in the Western world.

More than $20 million in PSRO contracts were awarded to 119 medical care foundations and associations in 38 states, Puerto Rico and the District of Columbia by HEW. Eleven conditionally operational PSROs were awarded more than $13 million; 91 organizations nationwide received planning contracts worth more than $5.5 million; and 13 state-level foundations and medical societies intending to function as statewide PSRO support centers received about $2 million. $2.8 million in contracts for training programs and technical work went to the AMA, American Association of Foundations for Medical Care, American Nurses Association and American Podiatry Association.

16,689 physicians received their first license in 1973. The figure represents the largest increase recorded in any one year, 15% higher than the 14,476 reported in 1972. There were 366,379 physicians in the U. S., including 326,933 licensed physicians, at the end of 1973.

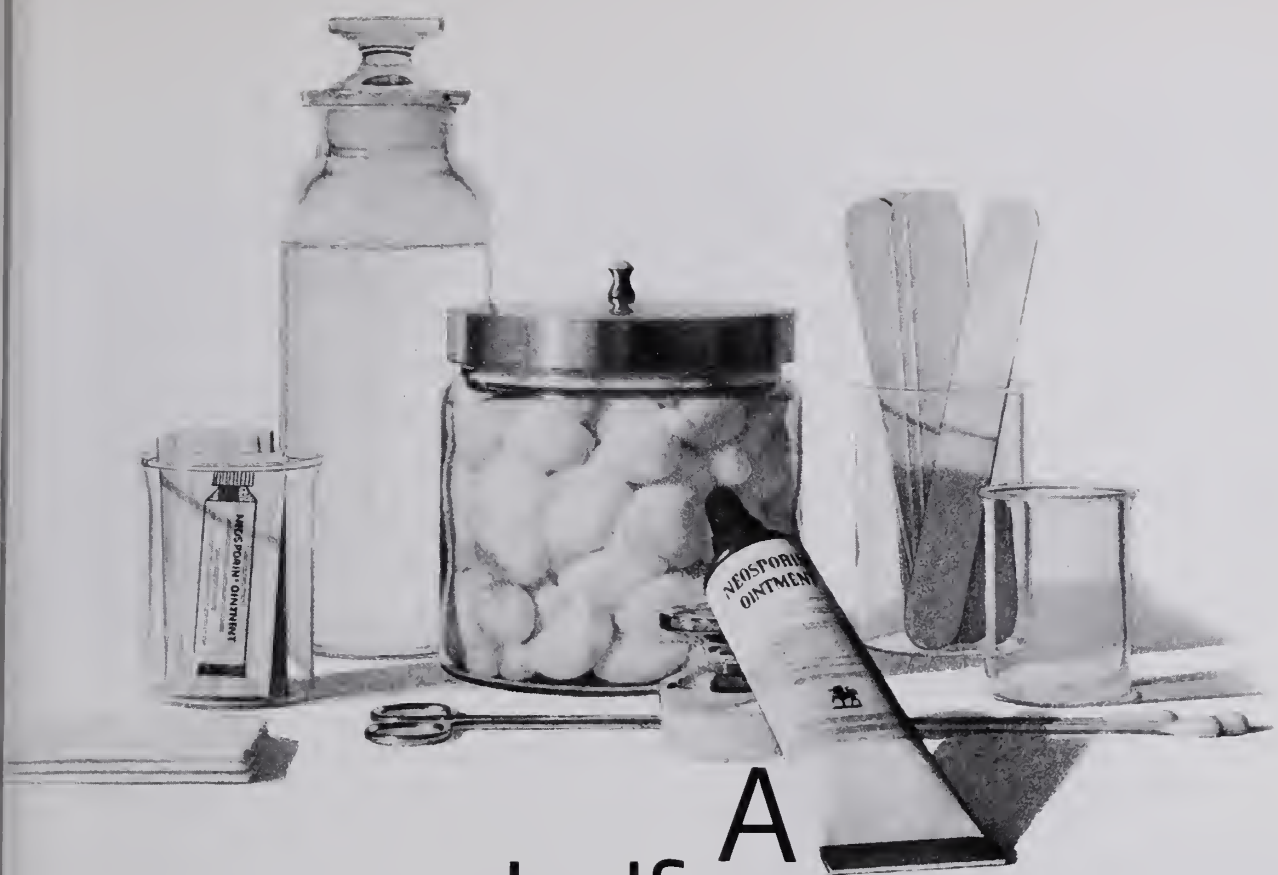
Mark your calendar for two upcoming AMA meetings in Chicago . . . The Fourth Biennial Conference on Continuing Medical Education for state medical associations and specialty societies on October 2-3 at the Drake Hotel. Contact Dept. of Continuing Medical Education, AMA Headquarters . . . The Second National Congress on Health Manpower on October 31-November 2 at the Palmer House. Contact Dept. of Health Manpower, AMA Headquarters.

Ethical and legal questions concerning physicians' participation in weight-reduction "clinics" that advertise the use of human chorionic gonadotropin injections are being raised. The widely advertised "fat clinics" which use HCG, a substance made from the urine of pregnant women, are offering physicians large sums of money to affiliate with them. The AMA and the FDA have both said that HCG has not been proven useful in the treatment of obesity. In two states, California and Michigan, either the state medical society or the attorney general has warned physicians of the ethical questions involved in affiliating with such a clinic.

The AMA has signed two contracts with HEW. An $111,000 grant from HEW's National Center for Health Statistics will finance a two-year research study by the AMA's Center for Health Services Research and Development to develop and refine new measures of the supply of physicians' services. The other contract, for $995,635, is for the development of model sets of criteria for screening appropriateness, necessity and quality of medical services in hospitals.

A national center for health education is being developed by the National Health Council under a $258,816 contract with HEW. The project, recommended by the President's Committee on Health Education, will seek to stimulate, coördinate and evaluate health education programs.

Available from AMA: "Health Care Functions and Responsibilities of Physicians' Assistants," a report of a survey of 300 PAs employed in health care settings during the summer of 1973. Write Dept. of Health Manpower, AMA Headquarters . . . Two pamphlets, "Helping Hands, Financing a Health Career" (OP-417) and "Helping Hands, The Challenge of Medicine" (OP-418), are designed to provide guidance for high school and college students interested in careers in medicine. To order, 30¢ each for 1-99 copies; 20¢ each for 100-499; 19¢ each for 500-999 and 18¢ each for 1,000 or more, write Order Dept., AMA Headquarters . . .



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Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs. In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

ICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic
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raumatic lesions, inflamed or suppurating as a result of bacterial infection.
Prophylactically, the ointment may be used to prevent bacterial contamination
urns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts
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ection and permit wound healing.

NTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum
erforated. This product is contraindicated in those individuals who have
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RNING: Because of the potential hazard of nephrotoxicity and ototoxicity
to neomycin, care should be exercised when using this product in treating
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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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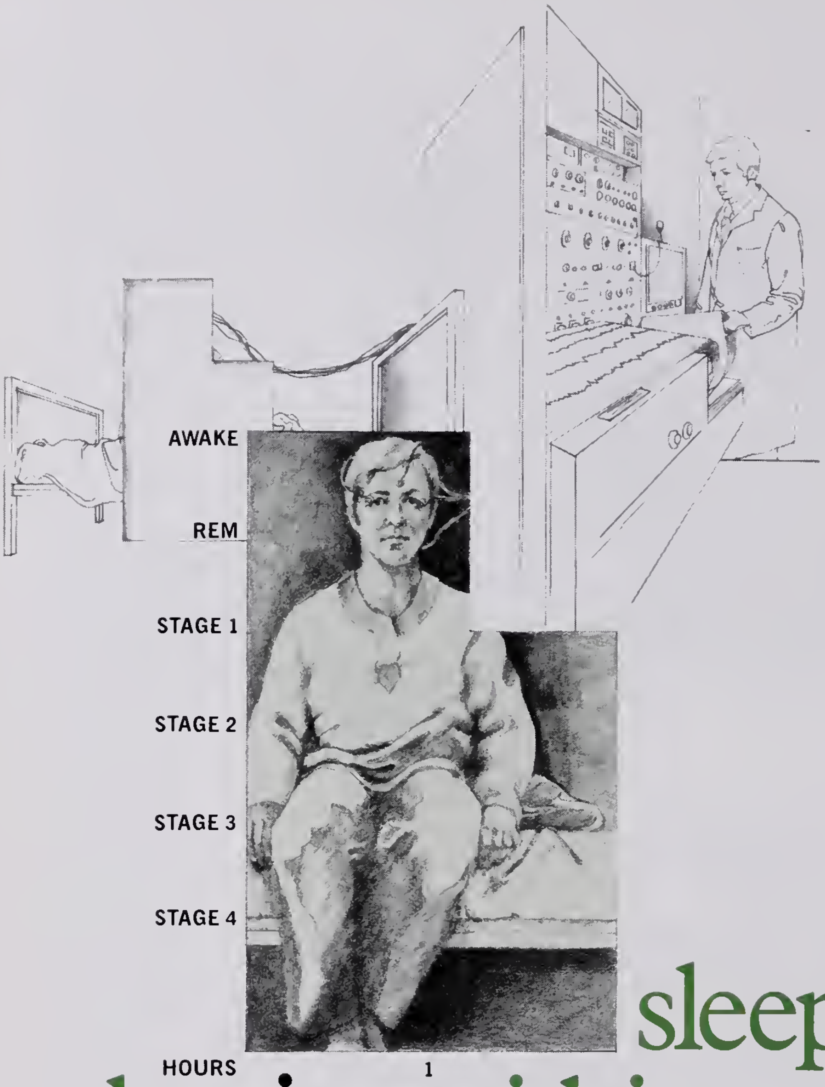

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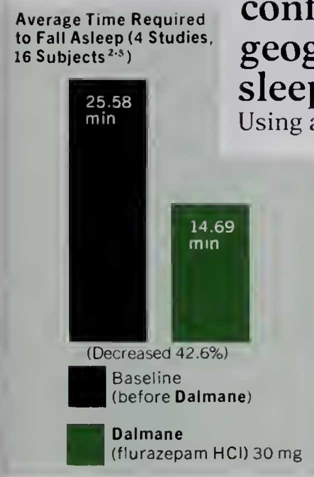

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Contraindications: Known hypersensitivity to flurazepam HCl.

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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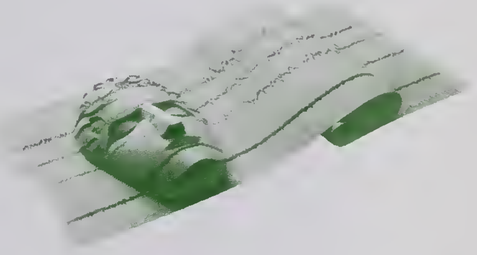

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H. RICHARD McFARLAND, M.D., *Kansas City*

Reappraisal of Levodopa Therapy For Parkinson's Disease

A Three-Year Experience With Outpatients in Private Practice

IN DECEMBER of 1969, permission was received from the Department of Health, Education and Welfare in Washington, D.C. for the experimental use of levodopa in the treatment of parkinsonism (#Ind. 6316). The aim of the study was to determine the benefits and complications during the use of levodopa for outpatients in a private-practice setting. After 26 consecutive patients were treated, the study was concluded in December, 1970. The first-year experience was published in MISSOURI MEDICINE.[1]

This report concerns a dispassionate reappraisal of an initial group of 26 outpatients treated by one neurologist in private practice in Kansas City, Mo. Those patients continuing on a regimen of levodopa have been followed for two or three years. At the start of this review, 20 patients continued taking this medication. Where feasible, reports on all 26 patients will be included in the statistical analysis.

RESULTS

The retrospective analysis began in December, 1972. Five additional patients were no longer taking levodopa. One had been removed from medication and died of a metastatic bronchiogenic cancer. One had developed intractable psychiatric disturbances; another experienced insufferable nausea and vomiting. A fourth patient had signs of brain stem insufficiency with orthostatic hypotension. A fifth showed no improvement and, in fact, felt a worsening of tremor and involuntary movements. Thus, 15 (58%) patients continued taking levodopa while 11 (42%) had not found it possible to continue (Table 1). The average age of those taking maintenance levodopa was 69 and for those discontinuing levodopa, 71. The highest maintenance dosage was 4 gm and the lowest was 2 gm in divided doses daily with an average of 3.0 gm.

In the initial investigation, patients were graded in three categories: mobility, strength and dexterity and the neurologic examination. If they improved in two or three of the categories, they were rated for good improvement; if in one, slight improvemet; and if in none, no improvement. Of the 15

TABLE 1

LEVODOPA STUDY

	#	%
Number of patients entered treatment	26	—
Number of patients continuing treatment	15	58
Number of patients discontinuing treatment	11	42
Number of patients died	4	15
Reasons for discontinuance		
Drug intolerance (nausea and vomiting)	3	
No clinical improvement (tremor)	2	
Psychosis (1 subsequently died of bronchopneumonia)	2	
Orthostatic hypotension (1 subsequently died of brain stem infarct)	2	
Terminal illness (subsequently died of malignancy)	1	
Death (myocardial infarction)	1	

In this sequel to his article on levodopa therapy for Parkinson's disease, which was published in the November, 1971 issue of MISSOURI MEDICINE, the author reappraises the initial group of 26 patients and reports the current experiences. The results should be of special interest to the physician in private practice. Dr. McFarland is Assistant Clinical Professor of Neurology, University of Kansas Medical Center; Instructor in Medicine, University of Missouri-Kansas City School of Medicine; and consultant in Neurology, Kansas City VA Hospital.

This paper was originally presented in part at the X Congreso International Neurologia, Barcelona, Spain on Sept. 8-15, 1973.

still receiving levodopa, four maintained good improvement, three showed slight improvement and eight showed signs of worsening or deterioration during this two-year period. Thus, of the initial 26 patients, only seven (27%) appeared to derive any lasting benefit from the use of levodopa.

Cerebral arteriosclerosis was a concomitant diagnosis in 22 of the 26 patients of the initial study. Only one of the 15 continuing treatment was considered free of these signs. Classical criteria are rather sudden onset of mental disturbance, hemiparesis with hyperreflexia or episodes of confusion, vertigo and ataxia, which is often associated with bruits or decreased blood flow in neck vessels and advanced arteriosclerosis of arterioles in the fundus and hypertension or hypotension. Admittedly, these changes can be due to other etiologies, but all patients remaining in the study were carefully reexamined at two-month intervals and received appropriate laboratory tests to exclude tumor, metabolic-endocrine disturbance, anemia and other causes.

Concomitant medications of the intreatment group of 15 patients were as follows: Nine patients were taking either a high dose of buffered nicotinic acid or papaverine hydrochloride orally. Nine patients were taking an anticholinergic drug, one of these with an antihistamine and four with a minor tranquilizer. One patient was taking amantadine with a minor tranquilizer. Five patients were taking no anticholinergic, antihistaminic or amantadine preparation. Two of the 15 required meclizine because of nausea related to the levodopa.

The average duration of symptoms of parkinsonism for the intreatment group was nine years and for the nontreatment group, six years. Of the latter group, four of 11 are dead of causes which cannot be related to parkinsonism or levodopa with any certainty.

DISCUSSION

The average age and frequent association of cerebral arteriosclerosis in this series is of more than casual interest. After permission was received to administer levodopa, each outpatient presenting with parkinsonism was offered treatment. At the end of 12 months, those who had the opportunity of treatment for at least one month became the study group. Those presently taking levodopa have an age range of 60 to 80 years with an average age of 69. In contrast, the Eaton Cooperative Study,[2] with 535 patients participating for two or more years, has but two thirds of the patients at 60 years or older. Care was taken not to include any patients with signs of a progressive dementia, bilateral cortical spinal tract disease or gegenhalten. The majority had a typical tremor at rest and, in addition, their rigidity was of a plastic or cogwheel type. Nevertheless, the treatment group's age and debilitation may account for its lower average maintenance dosage, fewer dyskinesias and less sustained improvement compared to other studies.

Regarding the long-term effectiveness of levodopa, there is considerable disagreement varying from reports indicating that after two and one-half years, two thirds of the patients are markedly improved[3] to a study suggesting that levodopa may not only improve mobility scores but also, may maintain them at a steady state for as long as 18 months.[4] However, in a similar report, one of the same authors (F.H.Mc.) acknowledges that a group of 100 patients at the end of two years, only 72 remained in the study and seven had died.[5] The same author further acknowledges that at the end of two years, only 50 showed 50% improvement. In order to obtain these results, the following side effects were suffered: at the end of two years, 44% had dyskinesias and 43% had nausea and vomiting; seven patients manifested cardiac symptoms and three of these died suddenly; and 28% showed evidence of dementia.[5] In another brief study in which one fourth of the patients had already stopped taking levodopa, the authors concluded that "the degree of improvement in some patients is not sufficient to justify continued therapy, especially if there are undesirable side effects."[6] More than conclusions inconsistent with their data, some institutional studies appear to press for favorable mobility ratings at the expense of the patient's comfort and health—a situation most private patients and their physicians will not abide. That 30% to 50% of the patients will develop mental changes, abnormal involuntary movements, cardiovascular and other side effects limiting treatment with levodopa is more in keeping with our personal experience.[7] Furthermore, when initially efficacious, levodopa steadily loses its effectiveness after six to 12 months.

Another ethical problem is whether or not to accept the long-term levodopa syndrome in exchange for an improved dexterity rating.[8] Barbeau states that approximately 80% of patients with parkinsonism receiving continuous levodopa therapy for two years will have episodes of involuntary movements (dyskinesias). The second part of the syndrome is "akinesia paradoxica" or the on-and-off phenomenon in which the patient has marked hypotonia, a weakness in his legs and an absolute inability to move for varying periods of time. The third part is the insidious onset of loss of memory, decrease in judgment and social deportment. Whether the latter is due to the natural progression of the disease or chronic levodopa therapy is open to question. Nonetheless, of the eight patients still receiving treatment and deteriorating, nearly all showed evidence of this mental condition. Although "freezing" is a common accompaniment of bradykinesia, the on-and-off phenomenon is quite discernible and two of the 15 treatment patients have displayed it. Dyskinesias were minor and infrequent, but three patients continuing treatment have been distressed by them.

This study took place in a private practice setting and raises several questions relative to the larger and less personalized, cooperative reports, as follows:

1. Are they overbalanced by younger, healthier, less afflicted patients than the average clinician will see?
2. Are they advocating higher levodopa dosages than private practice patients can or should tolerate for the sake of an improved mobility index?
3. Are they reporting the effectiveness of levodopa or of levodopa interacting with an anticholinergic compound plus a new physical therapy program?
4. When they occur, do mobility improvements justify the undesirable effects of long term levodopa therapy?

SUMMARY

Of 26 outpatients with parkinsonism who began therapy with levodopa two or more years ago, 15 (58%) remain in treatment. Of this remainder, eight are deteriorating mentally as well as in terms of dexterity and mobility. Four have maintained good improvement while three have maintained a slight improvement over their initial ratings. Their average age is 69, while the average age of those discontinuing treatment was 71. Twenty-two of the original group have had or continue to display signs of cerebral arteriosclerosis. The average duration of illness for the treatment group is nine years. Age, length of illness and signs of central nervous system impairment may be related to their lack of improvement and also to the lower maintenance dosage tolerated. Long-term maintenance levodopa may be advantageous for selected patients, but was ineffective or intolerable for the majority in this series. For the physician in private practice, the long-term benefits of levodopa therapy may be less than he has been given to expect from larger cooperative studies.

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The 28th AMA Clinical Convention will be held on Nov. 30-Dec. 3, 1974 at the Memorial Coliseum in Portland, Ore. Scientific general sessions, postgraduate courses, film symposia and scientific exhibits will be featured. For further details, write to Circulation & Records Dept., American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

ALBERT LAM, M.D., LESLIE WISE, M.D.
and **HARVEY BUTCHER, M.D.,** *St. Louis*

Role of Colostomy in Perineal Burns

One of the most important factors in the survival of patients with major burns after the initial shock phase is the prevention of wound sepsis. Although complete asepsis of large burn surface is practically impossible, various topical agents, such as silver nitrate, silver lactate, colloidal silver and sulfamylon, are effective in keeping large burn areas functionally "uninfected."[1-6] The efficacy of these agents is increased by applying the principles of surface debridement with frequent dressing changes, by the judicious use of cutaneous homografts and heterografts and by the prevention of external contamination.[6] The prevention of contamination presents a severe problem in patients with perineal burns, because these burns are exposed to constant fecal contamination. In this report, the value of a diverting colostomy in this situation is examined.

Clinical Material

The charts of all patients admitted to the Burn Unit at Barnes Hospital in St. Louis between the years 1966 and 1970 inclusive were examined retrospectively.

All patients with perineal burns were included in this study. As shown in Tables 1 and 2, there were a total of 31 patients. Their ages ranged from three to 82 years. The percentage of body surface burned ranged from 34% to 95% with 27 of 31 patients being burned on over 50% of body surface, attesting to the severity of the surface involvement when burns of the relatively protected perineum exist.

With the exception of a diverting colostomy, both groups were treated following the same protocol. In brief, all patients were initally given tetanus toxoid. In addition, they were given antibiotic prophylaxis in the form of 250 mg penicillin K, qid, and 500 mg prostaphylin, qid, in oral doses for adults and half these amounts for children. Topical 0.5% silver nitrate also was used in all cases until December, 1967 when it was replaced by topical silver lactate cream.[4, 6] Other antibiotics, such as gentamycin and carbenicillin, were used as culture sensitivities indicated in individual patients.

Prevention of wound sepsis is an important factor in the survival of patients with major burns. Since fecal contamination is a significant problem, diversionary colostomy is a feasible consideration. The procedure has few complications, lessens a formidable cause of wound contamination, decreases the death rate from septicemia and facilitates nursing care. The authors are from the Department of Surgery, Washington University School of Medicine.

Results

Table 1 shows data on 20 patients who did not have a colostomy. Three of these survived to eventually leave the hospital. Nine died within the first 48 hours. Of those surviving longer than 48 hours, seven succumbed to septicemia and one died of acute pulmonary edema, which was thought to be secondary to fluid overload. All autopsies were performed by the State Coroner since these were all accidental deaths.

Table 2 shows data on the 11 patients who underwent diverting colostomy during their hospital stay. With the exception of Patients #30 and #31 who had loop colostomies, all colostomies were sigmoid end colostomies done in the left lower quadrant using a grid-iron type, muscle splitting incision. In three patients (#23, #24 and #29), the colostomy had to be brought out through an area with third degree burn. In these patients, a belt-type colostomy bag was used instead of a stick-on type with no apparent major problems. There were three survivors in these 11 patients. Deaths were due to septicemia in three, pneumonia in two, bleeding stress ulcer in one, congestive heart failure in one and myocardial infarction in one. All wound cultures were performed and quantitated by the method of Brentano.[3]

Table 3 summarizes all our findings. Those patients who survived less than 48 hours were included for the sake of completeness only and are not a comparable group in this context. The survival rate of 27% is identical in the group with and without colostomy. There was, however, a 63% surface septicemic death rate in the group without colostomies, in contrast to 27% in the group with

TABLE 1

PATIENTS WITHOUT COLOSTOMY

Patients	Age (Years)	Sex	% Burn	Length of Hospital Stay (Days)	Cause of Death	Other Complications	Representative Wound Culture of Inner Thigh
# 1	5	M	70	<1	Burn shock	None	None
# 2	79	F	80	<1	Burn shock	None	None
# 3	79	F	60	<1	Burn shock	None	None
# 4	3	F	95	<1	Burn shock	None	None
# 5	15	M	93	1	Burn shock, Pulmonary embolism	None	None
# 6	39	M	64	1	Burn shock	Bleeding stress ulcer	None
# 7	4	F	80	1	Burn shock	Respiratory insufficiency, trachcostomy	None
# 8	23	F	80	1	Burn shock	Respiratory insufficiency	None
# 9	82	F	63	2	Burn shock, Pulmonary embolism	On steroids for arthritis, bleeding stress ulcer	None
#10	34	M	50	156	Septicemia	Jaundice	None
#11	50	M	39	24	Septicemia	None	Pseudomonas, not quantitated
#12	21	F	85	32	Septicemia	Post-burn abortion (4th month)	2.4 × 10^7 Pseudomonas
#13	68	M	40	16	Septicemia	Urinary infection	4.8 × 10^2 Pseudomonas
#14	5	F	95	15	Acute pulmonary edema	Gangrene of finger & toe (which required amputation)	6.4 × 10^3 Staph. epid. 5.2 × 10^6 Aerobacter cloaca
#15	9	M	85	27	Septicemia	None	7 × 10^6 Pseudomonas 24 × 10^3 Pseudomonas Aerobacter
#16	52	M	93	30	Septicemia	None	1.8 × 10^7 Pseudomonas
#17	55	F	84	8	Septicemia	Renal failure	8 × 10^5 Pseudomonas
#18	29	M	81	86	Well & discharged	None	2 × 10^4 Pseudomonas
#19	64	M	60	118	Well & discharged	None	Pseudomonas, not quantitated
#20	49	M	50	31	Well & discharged	None	1.8 × 10^2 Staph. epid.

colostomies. Surface septicemia was said to exist when the temperature was persistently 39C or higher and there was no apparent source other than surface burn infection. In Figs. 1 & 2, the results of serial inner thigh cultures are compared with the clinical course in two patients. In Patient #29, there was fall in the colony counts and the patient survived; in Patient #24, the colony counts did not change significantly and the patient died.

DISCUSSION

Patients with burns to the perineum generally have extensive total body surface involvement. In this group, the body surface burned ranged from 34% to 95%. Many of these bedridden patients had poor bowel control, partially explained by their general debility. Usually, these patients are placed on systemic antibiotics and given large fluid loads that often lead to frequent, uncontrollable semiliquid defecation.

Proponents for a diverting colostomy in these situations argue that stool is one of the worse forms of contaminants. It seems logical that diverting the fecal stream from the perineum should reduce a formidable source of perineal contamination. Our data show a septicemic death rate of 27% in the group with colostomies in contrast to 63% in the group without colostomies.

The wound cultures in Table 2 show the pre- and postcolostomy bacteriology. Pre- and postcolostomy cultures taken in the immediate vicinity of the anal opening would make the results more meaningful. In fact, cultures were taken from the inner thighs. There was an overall tendency to a decrease in

TABLE 2

PATIENTS WITH COLOSTOMY

Patients	*Age (Years)*	*Sex*	*% Burn*	*Length of Hospital Stay (Days)*	*Type of Colostomy*	*Primary Cause of Death*	*Other Complications or Operations*	*Representative Wound Culture of Inner Thigh**
#21	82	F	60	10	End sigmoid	Pneumonia	Congestive heart failure	A. 4×10^1 Diptheroids Staph. epid. B. 2×10^1 E. coli
#22	18	M	83	49	End sigmoid	Bleeding stress ulcer	95% gastrectomy septicemia	A. 10^5 E. coli B. 10^5 Pseudomonas
#23	5	M	90	21	End sigmoid	Bleeding stress ulcer	1. Gastrostomy & ligation of bleeders 2. Wound dehiscence	A. 3.4×10^6 Strep., E. coli Staph. epid., Klebsiella B. 5.8×10^6 Pseudomonas, Staph. epid., E. coli, Aerobacter Strep.
#24	33	M	90	50	End sigmoid	Septicemia	None	A. 2.6×10^6 Pseudomonas, E. coli B. 3.7×10^4 Pseudomonas
#25	30	M	90	50	End sigmoid	Bronchopneumonia	Methemoglobinemia	A. 3.4×10^4 Pseudomonas B. 1.6×10^6 Pseudomonas
#26	22	M	80	80	End sigmoid	Septicemia	Pulmonary edema, respiratory insufficiency, tracheostomy	A. 6.8×10^7 Pseudomonas Aerobacter B. 10×10^4 Pseudomonas
#27	61	M	70	13	Loop colostomy (local)	Massive myocardial infarction	None	Not available
#28	56	M	90	35	End sigmoid	Pneumonia	None	A. 1.5×10^6 Pseudomonas B. 1.3×10^5 Pseudomonas
#29	12	M	80	136	End sigmoid	Well & discharged	None	A. 2×10^4 Herellea, Klebsiella B. 1.1×10^5 Pseudomonas, Strep.
#30	41	M	34	114	Loop colostomy	Well & discharged	None	A. 2.3×10^5 Pseudomonas, Aerobacter B. Staph. epid.—scanty growth
#31	32	M	40	58	End sigmoid	Well & discharged	None	A. 1.6×10^7 Pseudomonas B. 1.2×10^5 Pseudomonas

*A. Pre-colostomy. B. Post-colostomy.

colony counts with a shift to pseudomonas post-colostomy. Whether this merely reflects bacteriologic selection secondary to oral antimicrobials is herein unanswered. The tendency to a decrease in colony counts, however, is suggestive of decreased bacterial contamination. Apart from this consideration, the procedure certainly facilitates time-consuming and difficult nursing care.

TABLE 3

SUMMARY OF DATA

Data	*Patients Without Colostomy*		*Patients With Colostomy*
	surviving less than 48 hours	surviving more than 48 hours	
Number of patients	9	11	11
% Burn	76.1 ± 12.0 (Range 60-95%)	69.3 ± 20.6 (Range 40-95%)	73.8 ± 19.8% (Range 34-95%)
Age (years)	36.5 ± 32.5 (Range 5-82)	39.6 ± 20.5 (Range 5-68)	35.6 ± 21.9 (Range 5-82)
Sex			
Male	3	8	10
Female	6	3	1
Hospital stay (days)	Less than two days	49.4 ± 46.3 (Range 8-156)	57.3 ± 38.2 (Range 13-136)
Number of deaths	9 (100%)	8 (73%)	8 (73%)
Number of survivors	None	3 (27%)	3 (27%)
Principal causes of deaths	Burn shock—9	Septicemia—7 Acute pulmonary edema—1	Septicemia—2 Pneumonia with respiratory failure—2 Bleeding stress ulcer—2 Myocardial infarction—1 Congestive heart failure—1
Septicemia death rate	None	63.6%	27.2%

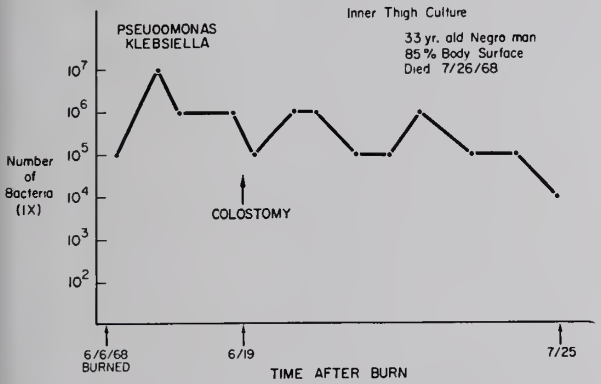

Fig. 1 Patient #24. The creation of the colostomy did not cause a significant fall in the number of inner thigh bacteria. The patient died.

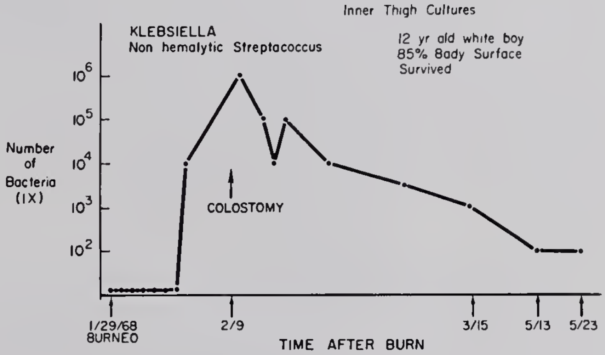

Fig. 2 Patient #29. Following the colostomy, there was a significant gradual decrease in the number of inner thigh bacteria. The patient survived.

In establishing the efficacy of any therapeutic modality, the benefits must be weighed against its potential hazards. In the patients examined, there were no complications referable to the colostomy. For the two patients who died of pneumonia, we have no clinical evidence of a cause and effect relationship between the operative procedure and the patients' ultimate deaths. Chronologically, these patients died 16 to 54 days after the operative procedure, which were well away from the immediate postoperative period. The operation is inherently short and in one of our cases, local anesthesia was used without difficulty.

Summary

Fecal contamination is a significant problem in patients with perineal burns, and diversionary colostomy is a feasible consideration. The procedure has few complications. It lessens a formidable cause of wound contamination, it decreases the death rate from septicemia and it facilitates nursing care. A randomized, prospective, controlled study would further delineate the value of this procedure.

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COREY A. BOHLING, M.D., *St. Louis*

Surgical Significance of the Cremaster Muscle in Adult Indirect Inguinal Hernia Repair

The author describes in detail a useful technique for exposure of the internal inguinal ring in all varieties of inguinal and femoral herniorrhaphies. He demonstrates that the cremaster muscle has no practical purpose and should be routinely sacrificed. Dr. Bohling is from the Department of Surgery, St. John's Mercy Medical Center.

DESPITE CONTROVERSY over which structures to use for the repair of adult indirect inguinal hernias, nearly all authors stress the basic principle of repairing the internal inguinal ring.[1] Most surgeons prefer tightening the ring by suturing transversalis fascia medially to anterior femoral sheath or iliopubic tract laterally, usually including the shelving portion of the inguinal ligament. When good exposure allows proper placement of sutures, the repair looks and feels physiologically perfect.

This author has noticed that visualization of the "V" shaped rim of transversalis fascia, which composes the inferior one half of the internal inguinal ring, is very difficult despite the pretty textbook pictures showing the vas deferens and spermatic vessels entering a cave-like hole with arrows pointing to beautiful exposure. Detailed explanations in the legends of atlases of surgical procedures never explain how this exposure is accomplished.

METHOD[2]

Since the external spermatic fascia begins at the external inguinal ring, the surgeon is concerned only with the middle and internal spermatic fascia at the internal inguinal ring after unroofing the inguinal canal. The cremaster muscle forms a rather thick covering of the spermatic cord as it takes origin from the inguinal ligament at and just above the internal inguinal ring. It is the sharp circumferential division of this muscle at this level which allows exposure of the internal spermatic fascia, investing the hernia sac, preperitoneal fat, vas and spermatic vessels. This is easily done after gaining circumferential control of the spermatic cord and placing traction so that one can feel the origin of the cremaster fibers closely attached to the inguinal ligament. There is very little give to these fibers, whereas the vas and vessels glide in and out of the retroperitoneal space, telling the surgeon what he can and cannot cut. After dividing the muscle, it retracts. The vas and vessels are easily cleaned of the remaining fibroareolar attachments to the transversalis fascia, allowing exposure of the internal ring and better visualization of the hernia sac neck for higher ligation after excision of occasional large elongations of preperitoneal fat protruding through the ring. This method should replace the tendency to incise the cremaster in the direction of its fibers, hunting for the hernia sac, frequently tearing the cremaster and, probably, occasionally damaging the internal ring and floor of the canal.

The question poses itself, "what is the importance of the cremaster muscle?" It may intrigue a neurologist who is interested in the integrity of the genitofemoral nerve, but to the surgeon it is merely an obstacle to a better inguinal hernia repair. Once the cremaster muscle is divided sharply and the hernia sac ligated and excised, the only structures left in the surgeon's hand are a slithering vas and spermatic vessels guiding him to the attenuated fascial edges he must repair.

One is struck by the consistently thick substance of the transversalis fascia of the inferior one half circumference of the internal inguinal ring and the obvious lack of a distinct fascial edge superiorly. Surely, this is why internal inguinal ring repair should be accomplished inferiorly and why superior sutures are considered "stabs in the dark."

This author has found that sharp division of the cremaster muscle also proves indispensable for all inguinal and femoral hernia repairs since reconstruction of the inguinal floor includes repairing the internal ring.

SUMMARY

The cremaster muscle has no practical purpose and should be routinely sacrificed for exposure of the internal inguinal ring, allowing for accurate place-

(Continued on page 546)

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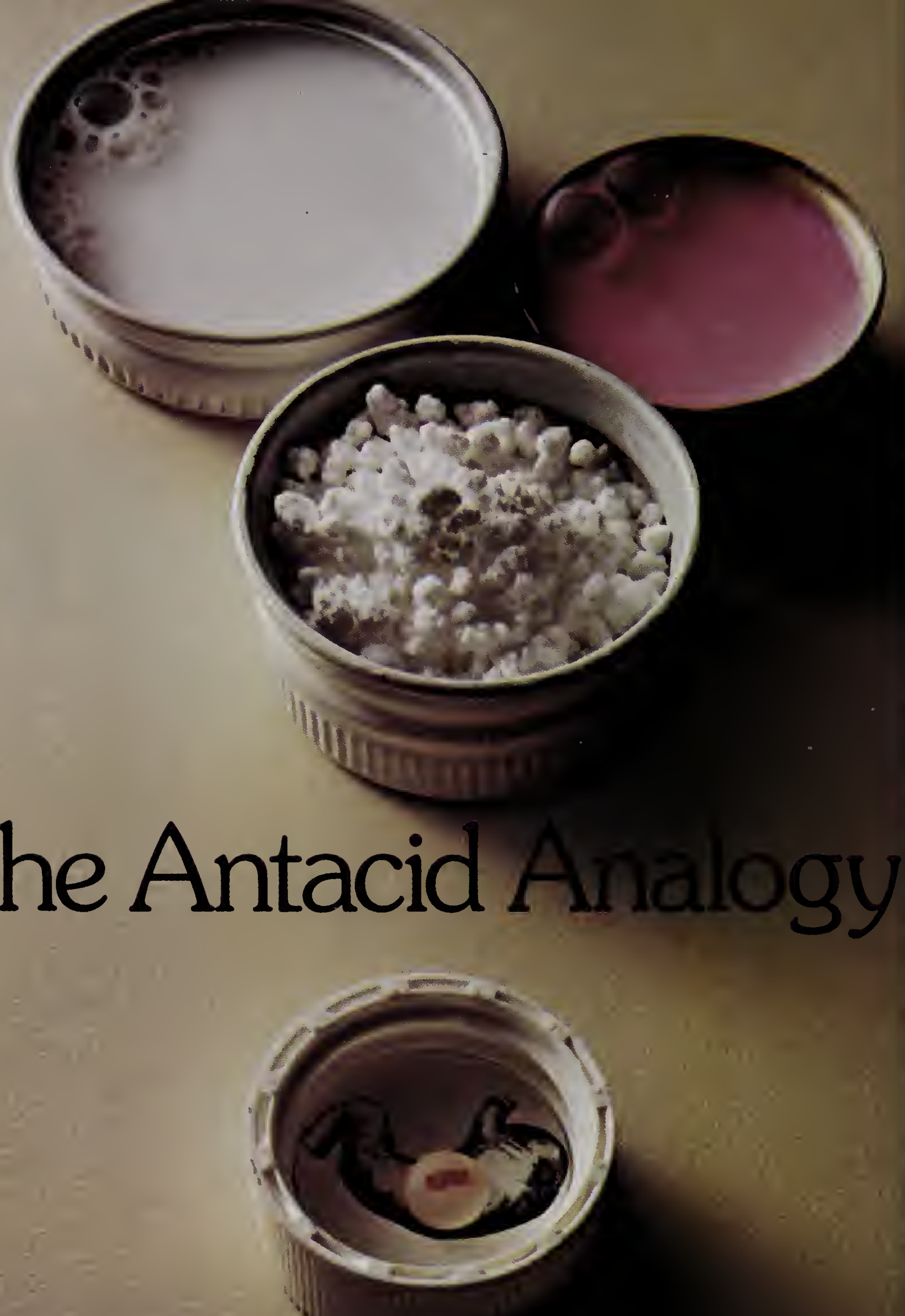

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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Opinion & Dialogue

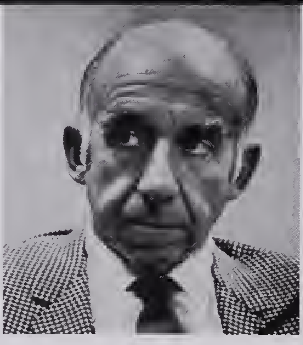
The Role of the Detail Man

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Dr. Willard Gobbell
Family Physician
Encino, California

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

He a Source of Information?

Yes, with certain reservations. e average sales representative s a great fund of information out the drug products he is re- onsible for. He is usually able to swer most questions fully and elligently. He can also supply rints of articles that contain a eat deal of information. Here, o, I exercise some caution. I usu- y accept most of the statements d opinions that I find in the pers and studies which come m the larger teaching facilities. goes without saying that a physi- an should also rely on other urces for his information on armacology.

aining of Sales Representatives

Ideally, a candidate for the sition as a sales representative a pharmaceutical company ould be a graduate pharmacist o has a questioning mind. I don't nk this is possible in every case, d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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pacity they are indeed useful; rticularly in the fact that they sseminate broadly based educa- nal material and serve not just "pushers" of their drugs.

e Other Side of the Coin

Obviously, the pharmaceuti- l companies are not producing all s material as a labor of love— ey are in the business of selling oducts for profit. In this regard e ambitious and improperly moti- ted sales representative can ert a negative influence on the acticing physician, both by pre- nting a one-sided picture of his oduct, and by encouraging the actitioner to depend too heavily drugs for his total therapy. In ese ways, the salesman has often storted objective reality and dermined his potential role as an ucator.

e Industry Responsibility

Since the detail man must be information resource as well as epresentative of his particular armaceutical company, he ould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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JAMES G. BLYTHE, M.D., KURT F. STROBACH, M.D.
and **PHILLIP C. HIGGINS, M.D.,** ***Creve Coeur***

Carcinoma in Situ of the Cervix

A Private Hospital Study

In 1943, the introduction of vaginal cytology by Papanicolaou and Trout made detection of carcinoma in the preinvasive stage a 100% curable lesion. One realizes the magnitude of this achievement when considering that prior to 1943, carcinoma of the cervix was considered as only invasive in nature. It was diagnosed by biopsy of an obvious lesion with a five-year cure rate of 35%.

The purpose of this study was to evaluate the diagnostic techniques employed and the management of patients with carcinoma in situ at a large, private metropolitan hospital. These patients were treated by 40 different physicians, including residents, each of whom is unique in his own diagnostic ability and technique.

Methods and Materials

This study included all cases of carcinoma in situ of the cervix from Jan. 1, 1962 until Dec. 31, 1971. There were 304 patients (279 private and 25 clinic) with this diagnosis. Forty physicians, including house staff, were responsible for their care. The average age was 38.3 years (Fig. 1). The youngest was 19 and the oldest was 80.

The symptoms and admitting diagnoses were tabulated according to the Papanicolaou smear classification. The most common gynecological complaints accompanying a Class III Pap Smear were pelvic pain, spotting and menorrhagia.

There were three diagnostic modalities used in this study. The most common method was cold knife conization of the cervix. Table 1 lists the other diagnostic modalities employed. There were 17 cases of carcinoma in situ of the cervix diagnosed on a hysterectomy specimen with no previous evidence of any abnormality.

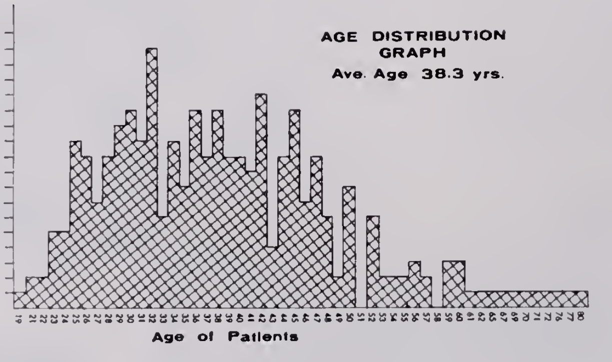

Fig. 1

TABLE 1

METHOD OF DIAGNOSIS

Conization	
Cold	**214**
Cryostat	**68**
Hot	**1**
Hysterectomy	
Abdominal	**14**
Vaginal	**3**
Cervical Biopsies	**4**
Total	**304**

The methods of treatment are shown in Table 2. The main treatment modality was either abdominal or vaginal hysterectomy. Two hundred and twenty-nine of the patients had abdominal hysterectomies and 38 of the patients had vaginal hysterectomies. Two of the patients had cervicectomies for removal of the residual cervical stump.

Thirty-five patients were treated only by conization. Of these 35, one patient had carcinoma in situ diagnosed by multiple cervical biopsies. In the conization, there was no residual carcinoma in situ. Five were pregnant at the time. Five had infertility

TABLE 2

METHODS OF TREATMENT

Hysterectomy	
Abdominal	**229**
Vaginal	**40**
No treatment	
Biopsy	**1**
Desirous of Pregnancy	**18**
Pregnant	**5**
Infertility	**5**
Desire	**8**
Age	**9**
Unknown	**7***

problems. Eight patients desired future pregnancies. "Age" was considered a contraindication to major surgery in nine patients. Seven of the patients did not receive therapy at this hospital. Two of these patients have had hysterectomies at other institutions. The therapy for the remaining five patients is unknown.

RESULTS

Fifty-six per cent (171/304) of the patients were admitted because of an abnormal Pap smear. Two hundred and fifty-three of the 304 patients had both a diagnostic procedure and definitive therapy. Of these 253 patients, 178 had no residual carcinoma in situ and 75 had residual carcinoma in situ in the hysterectomy specimen. Of the patients, 29.2% (75/253) had residual carcinoma in situ following a diagnostic procedure (Table 3). The average follow-up time was 36.5 months for 224 patients (Fig. 2). There were no cases of recurrent or persistent disease in these 224 patients. There was a total of eight pregnant patients. Five had only conization and follow-up is available on only one of these patients and her Pap smears have all been negative.

TABLE 3

PERCENT OF RESIDUAL
DX PROCEDURE & HYSTERECTOMY

Cases	253
No Residual	178
Residual	75

29.2% Had Residual Ca-In-Situ

DISCUSSION

We found the results to be in keeping with those of most major teaching hospitals.[1-4] Of the patients diagnosed with carcinoma in situ 29.2% had residual disease in the hysterectomy specimen following a diagnostic procedure. This, of course, may be due to a number of possibilities. The most likely is that the original conization was inadequate. It does point out the fact that a person with carcinoma in situ treated only with conization is risking inadequate therapy. This slight risk may be acceptable if the patient and her physician realize this risk and close follow-up examinations are maintained.

This is a report of a retrospective study of 304 private and clinic patients who were treated between January, 1962 and December, 1971. Purpose of the study was to evaluate the diagnostic techniques employed and the management of patients with carcinoma in situ in a large, private metropolitan hospital. The patients were treated by 40 different physicians, each of whom is unique in his own diagnostic ability and technique. The results, which are cited, compare well with those of most major teaching hospitals. The authors are from the Department of Obstetrics and Gynecology, St. John's Mercy Medical Center. Dr. Blythe is Chairman of the Department.

Follow-up Pap smears were obtained on 74% of the patients for an average of 36.5 months with no known recurrences. Three of the eight patients who were pregnant and had had conizations during pregnancy eventually had hysterectomies following vaginal delivery. All three of the patients had residual disease in the hysterectomy specimen. This

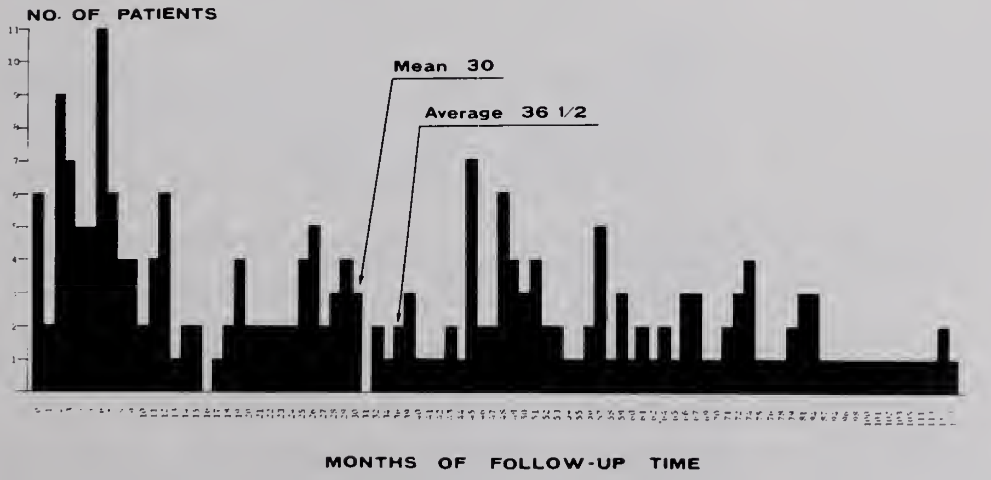

Fig. 2

was probably because a shallow conization was performed for fear of interrupting the pregnancy.

The information was obtained via the private physicians' records and hospital records and by contacting the individual patient. There was very little uniformity among these physicians in performing a total hysterectomy and no effort was made to remove extraparacervical tissue or large vaginal cuffs. The fact that there are no known recurrences in the 224 patients followed supports the view that total hysterectomy is adequate therapy for carcinoma in situ of the cervix.

There were no operative mortalities or ureteral or bladder injuries in this study.

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Cremaster Muscle

(Continued from page 542)

ment of sutures and negating inadvertent damage to important supporting tissue. This technique is useful for all varieties of inguinal and femoral herniorrhaphies.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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President's Message

The Cost of Medical Care

Secretary Weinberger of HEW has finally laid it on the line. He has stated that the cost of medical care is the prime problem of the health care industry. What he really meant was that it costs a lot to get sick—so much, in fact, that he is worrying about even the government being able to pay for it. Now, we know that HMOs, NHI and PSROs are really cost-containment ploys and have nothing to do with quality care. This may be good politics, but it surely is poor medicine. Having had a chance to study the attitude of the English people toward their National Health Scheme, I am convinced that availability or "for-free" are a lot more important to the public than quality.

James C. Cope, M.D.

In my opinion, there are three reasons for the high cost of being sick. First is inflation. The cost of everything the hospitals need to operate has risen at least at the same rate as everything else. Labor, food and supplies are no respectors of the sick. Hospitals must pay for them. More and more expensive equipment is now considered a necessity.

Second is that we are expected to do more and can. During my intern days, fractured hips were the most fatal disease I treated. They were treated with traction or a body spica and most of the patients died within a week from hypostatic pneumonia. We didn't have the antibiotics to keep them alive. Now, the hips are pinned and the patients are kept alive with antibiotics and early motion. As a result, they live to break the other hip or, finally, end up with a full hip prosthesis.

It's going to cost more, a lot more, and I for one don't intend to allow myself to be maligned for it. I now have a patient who has survived three malignant GU tumors. He had a seminoma which was treated with orchiectomy and radiation. He subsequently had a kidney removed for a hypernephroma and, more recently, he has undergone a radical prostatectomy for cancer of the prostate. Not too many years ago, his first tumor would have killed him and society would have been spared the cost of his other two illnesses. I do not feel guilty that his GU system has been expensive. When each individual receives more care, the aggregate cost will be greater. I do not see why anyone should point the accusing finger at the doctor because he can and does do more for his patients.

Third is the overuse of medical facilities by the worried patient or the worried-about malpractice doctor. It costs just as much to take and read a normal chest x-ray as it does for one that shows lung cancer. Our patients and society demand that we do every appropriate and some questionably-appropriate tests and diagnostic procedures for the most flimsy reasons.

If the social planners want a national prepaid system of medicine, they had better find out a way to pick up the tab first. When medical care becomes available to all and "for-free," there is going to be a demand that is almost beyond imagining.

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Woman's Auxiliary

50th Anniversary

Education for the Future

Health Education? Education for Health? Whichever way it is stated, this subject is a major concern of the Woman's Auxiliary. Mrs. Howard Liljestrand, President of the Woman's Auxiliary to the AMA, has stated, "To be champions of school curricula on effective, healthful living is certainly a project of great magnitude."

Stop to consider all of the ramifications of this subject and you will find them overwhelming. Every day, we read of fad diets (nothing but bananas). We read of quack cures for cancer and arthritis, as well as about the uses and abuses of drugs and alcohol (witness the recent Sedalia "festival"). Unfortunately, Mr. and Mrs. John Q. Public are vulnerable to appealing claims, even though they are false. Something must be done to improve the quality of health education for everyone and increase its dissemination.

Do you know if health education is included in the curricula of schools in your community and, if so, to what extent and quality? Are your health educators well trained? Answers to these and other questions will be sought by the committees on health education in all counties in which there are active medical society auxiliaries. This will be a major project for county auxiliaries in all 50 states.

The Auxiliary can make a great contribution to America if we can be effective in a movement to improve the quality of health education for our citizens from the crib to the mortar board. This is another facet of the opportunities offered to AMA and MSMA auxiliary members as participants in community affairs. Is your wife a member?

Mrs. George J. Lytton
President

EDITORIAL

BLUE SHIELD AND THE FEDERAL EMPLOYEE PROGRAM

On June 10, 1974, a letter was sent by St. Louis Blue Shield to physicians practicing in the St. Louis Blue Shield area. This editorial is prompted by this letter which referred to a policy to be instituted in paying for services rendered to patients covered by the Federal Employee Program.

As I understand the letter, it proposes to make much faster payments to physicians for inpatient care. However, it includes the following reservation in regard to an instance in which lack of necessity of hospitalization was not immediately evident and benefits were paid. If, after a more time consuming review, Blue Shield feels that hospitalization was primarily for diagnostic purposes, "it will be necessary that we ask for a refund of all or a portion of the benefits previously paid."

Actually, the ground rules for determining benefits has not been changed, and I think we agree that hospital beds should not be used for services which could be "satisfactorily and safely" performed on an outpatient basis. On reading that letter, however, I think that many of us were stirred by the same uneasy feelings we have had in reading of retrospective retraction of payments by Medicare for hospital or extended care treatments. Those of us who have had the opportunity of preparing lengthy explanations of services and charges to insurance carriers are coming to the cold realization that this rare incident may become commonplace should the length or type of care fall outside a statistical "norm."

As physicians, most of us are supporters of our Blue Plans. It should be pointed out again that the letter referred only to the Federal Employee Program, although it would seem to be a sad state of affairs to have to put a special tag on the records of certain groups of patients.

I think most of us would prefer the approach of continuing our present effort to improve utilization of hospital beds for all patients, regardless of the insurance carrier or the particular group.

It should be obvious that an insurance company should enforce the provisions of its policy. However, it is time the insurance carriers assume the responsibility for making certain that their members fully understand which benefits are NOT provided. (For instance, use larger type in that part of the advertising brochure or policy.) A concerted educational effort to members already enrolled would seem to be a better approach than what seems to be a politely-worded, threatening letter to physicians.

The physician's job is to care for his patients as effectively and economically as he can. I feel it is not his job to explain to patients what particular benefits they or their employers have purchased.

JOSEPH V. FINNEGAN, M.D., Editor

LETTERS to the Editor

To the Editor:

Re: "Low Back Syndrome and Inguinal Hernia" by Gilbert N. Lasser, M.D. (MISSOURI MEDICINE, Vol. 71, No. 5)

Dear Sir:

The article by Dr. Lasser is particularly apropos for women. All that glitters is not gold—hernia pain may not be due to the hernia, and right and left lower quadrant pain in women may not be "female trouble." Lower abdominal pain in women can be particularly exasperating in face of a normal pelvic exam, especially when the patient comes in with her own diagnosis of "my ovaries are bothering me." The mistake is further propagated by a rough examining hand on the ovaries producing pain and making the patient jump and confusing the physician and the patient to the fact that she has "female trouble" or infection.

A differential diagnosis in these patients gets rather lengthy, but the point I would like to make is that these women not infrequently are suffering from low back syndrome. To illustrate, here is my most recent case of a 19-year-old, single, white woman who has been treated for three recurrent episodes of PID by two different physicians on an outpatient basis. She came to my office with her third episode of pain. Her menses are normal. Her past history is negative except for pain. Her vital signs and the physical exam are normal except for guarding in the right lower quadrant on pelvic exam alone. Examination of the back reveals trigger-point reproduction of her pain and injection of Xylocaine Cortisone Solution gives her immediate and complete relief.

Many women have had unnecessary antibiotics and unecessary surgery even to the point of pelvic cleanouts because of persistent chronic pelvic pain when all they had was low back syndrome.

We all can thank Dr. Lasser for calling this problem to our attention and hope that more gynecologists will see the corollary and get their patients out of the lithotomy position and examine their back and make the proper diagnosis.

Sincerely,
H. T. Huddleston, M.D.
Smithville

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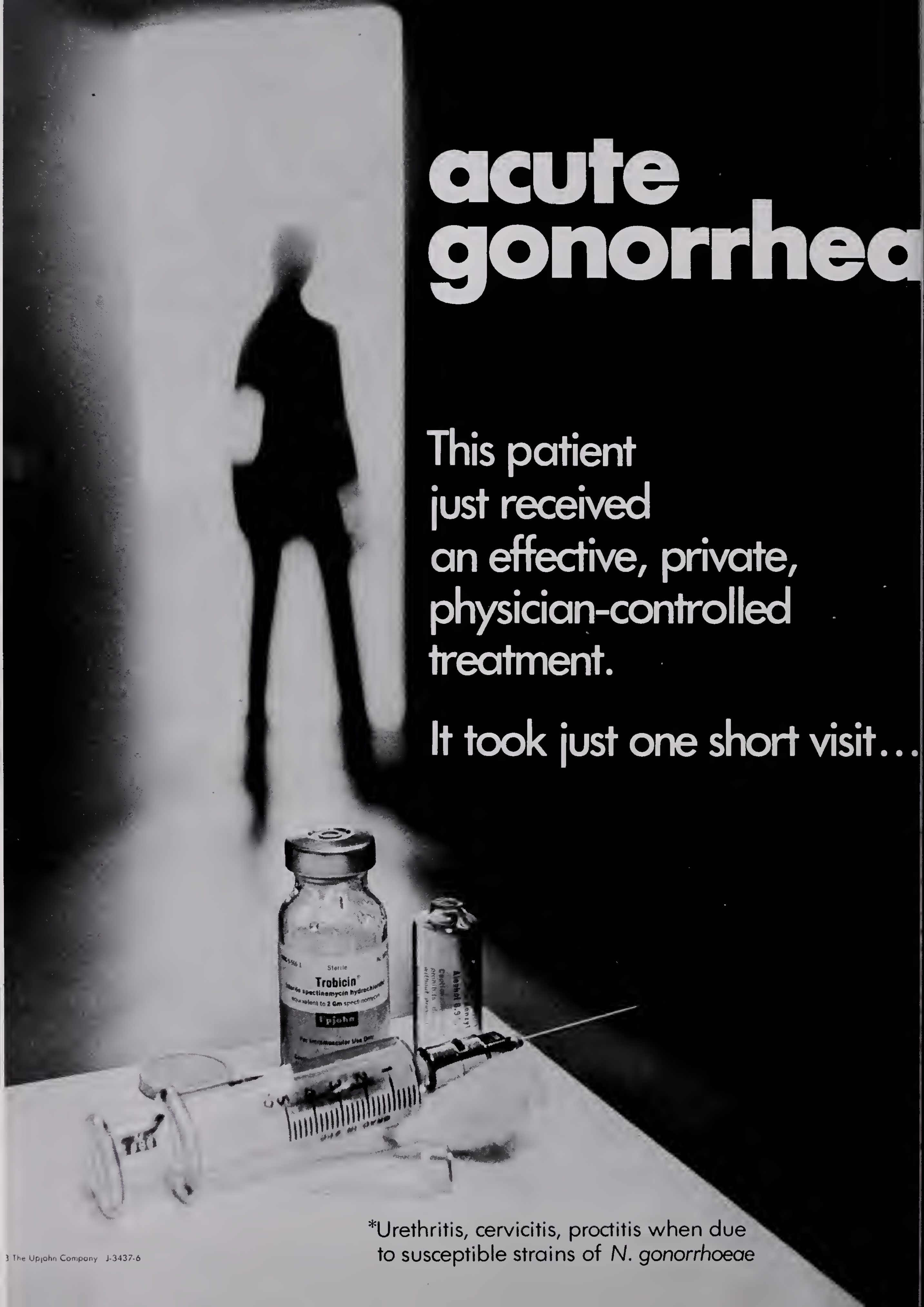
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Trobicin—The advantage of injectable therapy.
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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.
Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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aminocyclitol antibiotic active *in vitro* against st strains of *Neisseria gonorrhoeae* (MIC 7.5 20 mcg/ml). Definitive *in vitro* studies have wn no cross resistance of *N. gonorrhoeae* ween spectinomycin and penicillin.

dications: Acute gonorrheal urethritis proctitis in the male and acute gonorrheal vicitis and proctitis in the female when due susceptible strains of *N. gonorrhoeae*.

ntraindications: Contraindicated in pants previously found hypersensitive to specmycin.

arnings: Not indicated for the treatment of hilis. Antibiotics used to treat gonorrhea y mask or delay the symptoms of incubating hilis. Patients should be carefully examined monthly serological follow-up for at least nonths should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
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Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
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How supplied: *Vials, 2 and 4* grams—*with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
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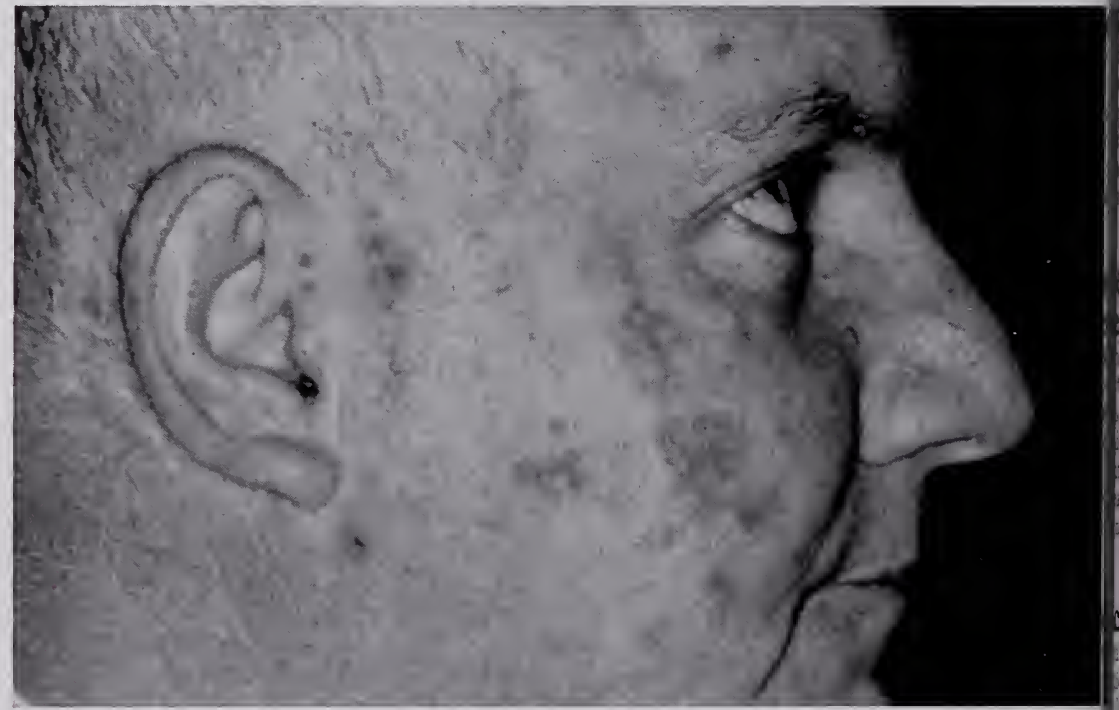
for patients with gonorrheal proctitis and for patients in geographic areas where antibiotic sistance is known to be prevalent, initial treatment with 4 grams is preferred.

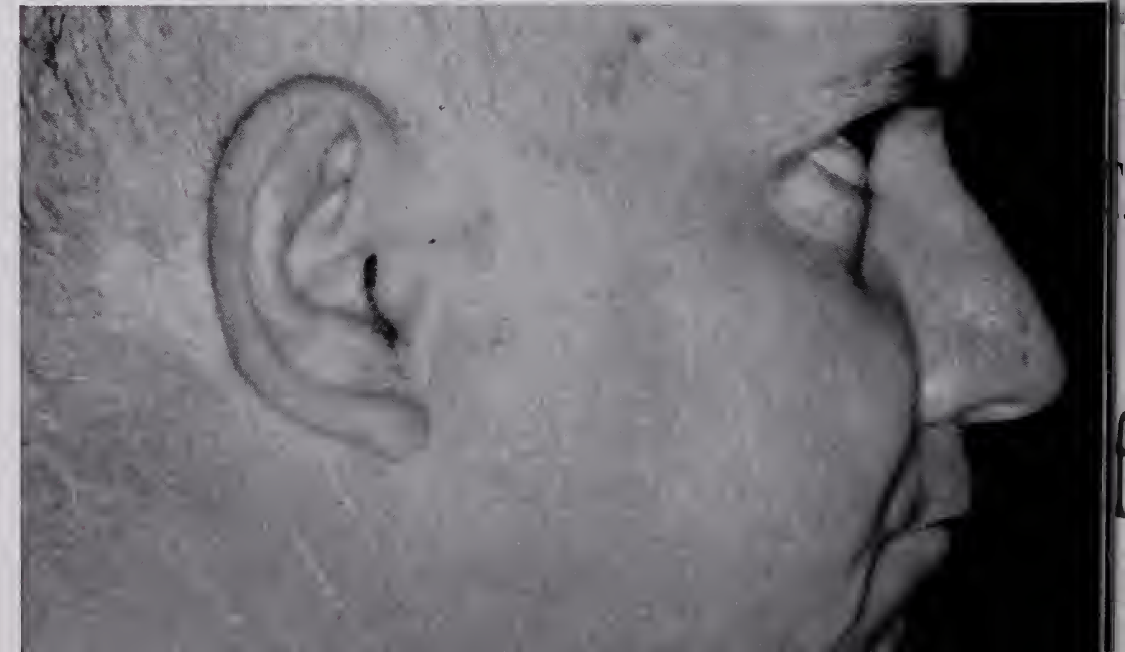
What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.



*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

[he lesions on his face ıre solar/actinic– o-called "senile" keratoses... ınd they may be premalignant.

olar, actinic or senile keratoses

ıese lesions may be called by several names, but they ually can be identified by the following characteris- s. The typical lesion is flat or slightly elevated, of a ownish or reddish color, papular, dry, rough, adherent d sharply defined. They commonly occur as multiple ions, chiefly on the exposed portions of the skin.

equence of therapy– electivity of response

ter several days of therapy with Efudex® (fluorouracil), ythema may begin to appear in the area of the lesions; is reaction usually reaches its height of unsightliness d discomfort within two weeks, declining after dis- ntinuation of therapy. This reaction occurs in affected eas. Since the response is so predictable, lesions that not respond should be biopsied.

cceptable results

eatment with Efudex provides highly favorable cos- etic results. Incidence of scarring is low. This is par- ularly important with multiple facial lesions. Efudex ould be applied with care near the eyes, nose and mouth.

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Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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New Members

Edwin E. Cohen, M.D., 751 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Cohen is a native of Harrisburg, Pa., received his preliminary education at Dickinson College and his M.D. degree at Thomas Jefferson University in 1965. He specializes in general surgery.

William E. Davis, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Davis is a native of Kansas City, received his preliminary education at Rockhurst College and his M.D. degree at the University of Missouri in 1966. He specializes in otolaryngology.

Anthony P. Friedrich, M.D., VA Hospital, St. Louis, has become a member of St. Louis Medical Society. Dr. Friedrich is a native of Chicago, Ill., received his preliminary education at the University of Illinois and his M.D. degree at St. Louis University in 1971. He specializes in radiology.

Gerald Hobson, M.D., 122 Manchester Rd., Ballwin, has become a member of St. Louis Medical Society. Dr. Hobson is a native of Pennsylvania, received his preliminary education at the University of Chattanooga and his M.D. degree at the University of Tennessee in 1967. He specializes in ophthalmology.

Malcolm E. Kendall, M.D., 2316 E. Meyer, Kansas City, has become a member of Jackson County Medical Society. Dr. Kendall is a native of Fort Royal, Va., received his preliminary education at Duke University and his M.D. degree at Duke University in 1967. He specializes in cardiovascular diseases.

Howard L. Mussell, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Mussell is a native of Des Moines, Ia., received his preliminary education at the University of Iowa and his M.D. degree at the University of Missouri in 1967. He specializes in general surgery.

Carroll D. Patterson, M.D., 2900 Hospital Dr., Kansas City, has become a member of Clay County Medical Society. Dr. Patterson is a native of Adrian, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1965. He specializes in psychiatry.

Aphiraks Tokrisna, M.D., 10901 Winner Rd., Independence, has become a member of Jackson County Medical Society. Dr. Tokrisna is a native of Bangkok, Thailand, received his preliminary education at the Faculty of Pre-Medical Sciences and his M.D. degree at Chiengmaik Hospital in 1965. He specializes in allergy.

Yolvilai Sethabutra, M.D., 1515 Lafayette, St. Louis, has become a member of St. Louis Medical Society. Dr. Sethabutra is a native of Thailand, received her preliminary education at Wattana Wittaya Academy and her M.D. degree at Mahidol University in 1970. She specializes in pediatrics.

Neil A. Shank, D.O., 701 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Shank is a native of Newark, N. J., received his preliminary education at Rutgers University and his M.D. degree at the Kansas City College of Osteopathic Medicine in 1971. He specializes in internal medicine.

William D. Shanks, M.D., 8655 Old Bonhomme Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Shanks is a native of North Carolina, received his preliminary education at North Carolina College and his M.D. degree at Meharry College in 1969. He specializes in ophthalmology.

Julius K. Sheppard, M.D., 902 Edmond, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Sheppard is a native of El Dorado, Ark., received his preliminary education at the University of Arkansas and his M.D. degree at the University of Arkansas in 1967. He specializes in orthopedics.

Victor A. Silva, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Silva is a native of Venezuela, received his preliminary education at Massachusetts Institute of Technology and his M.D. degree at St. Louis University in 1971. He specializes in pathology.

Charles H. Smith, D.O., 5008 N. E. 45th Terr., Kansas City, has become a member of Clay County Medical Society. Dr. Smith is a native of Otterman, Ia., received his preliminary education at Northeast Missouri State University and his M.D. degree at the Kansas City College of Osteopathic Medicine in 1956. He specializes in general practice.

Somnuk Srivisal, M.D., 8147 Briar Haven, St. Louis, has become a member of St. Louis Medical Society. Dr. Srivisal is a native of Thailand, received his preliminary education at Bangkok Christian College and his M.D. degree at Chiang Mai University in 1969. He specializes in radiology.

H. Todd Stradford, M.D., Clark Hall, Columbia, has become a member of Boone County Medical Society. Dr. Stradford is a native of Birmingham, Ala., received his preliminary education at the University of Chicago and his M.D. degree at the University of Chicago in 1938. He specializes in orthopedics.

Cengis M. Sumer, M.D., 103 N. Taylor, St. Louis, has become a member of St. Louis County Medical Society. Dr. Sumer is a native of Turkey, received his preliminary education at Istanbul University and his M.D. degree at the University of Istanbul in 1951. He specializes in psychiatry.

Shankar Sundaram, M.D., 13211 Greenbrough, St. Louis, has become a member of St. Louis Medical Society. Dr. Sundaram is a native of India, received his preliminary education at Christian College and his M.D. degree at Christian Medical College in 1962. He specializes in anesthesiology.

Morfeo M. Suva, M.D., 440 S. Market, Springfield, has become a member of Greene County Medical Society. Dr. Suva is a native of the Philippines, received his preliminary education at the University of the East and his M.D. degree at the University of the East in 1965. He specializes in internal medicine.

Manu Tongwarin, M.D., 4672 S. Spring, St. Louis, has become a member of St. Louis Medical Society. Dr. Tongwarin is a native of Thailand, received his preliminary education at Provineed School and his M.D. degree at the University of Medicine in 1969. He is a resident in obstetrics and gynecology.

Roger V. Vardeleon, M.D., 327 Conway Lake Dr., St. Louis, has become a member of St. Louis Medical Society. Dr. Vardeleon is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1963. He specializes in general surgery.

Frank R. Victor, M.D., 701 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Victor is a native of Topeka, Kan., received his preliminary education at Ottawa University and his M.D. degree at the University of Kansas in 1968. He specializes in radiology.

William H. Warren, M.D., 1423 N. Jefferson, Springfield, has become a member of Greene County Medical Society. Dr. Warren is a native of New York, N. Y., received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1968. He is an emergency room physician.

P. Wichienkuer, M.D., 1221 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Wichienkuer is a native of Thailand, received his preliminary education at Trium Udom School and his M.D. degree at Siriraj Medical School in 1967. He specializes in neurology.

Marsha V. E. Zinn, M.D., 44th and Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Zinn is a native of Brewster, Kan., received her preliminary education at Kansas State University and her M.D. degree at the University of Kansas in 1967.

In Memoriam

Joseph B. Guccione, M.D., 1040 N. Mason Rd., St. Louis, a graduate of St. Louis University, 1935; member of St. Louis Medical Society; age, 64; died June 23, 1974.

Carl T. Rinker, Jr., M.D., 2930 S. Glendale, Springfield, a graduate of the University of Colorado, 1956; member of Greene County Medical Society; age, 44; died June 24, 1974.

Johnson Underwood, Jr., M.D., Professional Bldg., Kansas City, a graduate of Rush College, 1935; member of Jackson County Medical Society; age, 66; died July 12, 1974.

Raymond O. Muether, M.D., 6744 Clayton Rd., St. Louis, a graduate of St. Louis University, 1929; member of St. Louis Medical Society; age, 69; died July 13, 1974.

John P. Frick, M.D., 116 Huntington Rd., Kansas City, a graduate of Washington University, 1923; member of Jackson County Medical Society; age, 75; died July 14, 1974.

John R. Post, M.D., Post Drive, Washington, a graduate of St. Louis University, 1966; member of St. Louis Medical Society; age, 39; died July 15, 1974.

Edwin H. Rohlfing, M.D., 315 N. Forsyth Blvd., St. Louis, a graduate of Washington University, 1919, member of St. Louis County Medical Society; age, 80; died July 16, 1974.

Harold H. Cline, M.D., Piedmont, a graduate of the University of Arkansas, 1937; member of Butler-Wayne-Ripley County Medical Society; age, 64; died July 23, 1974.

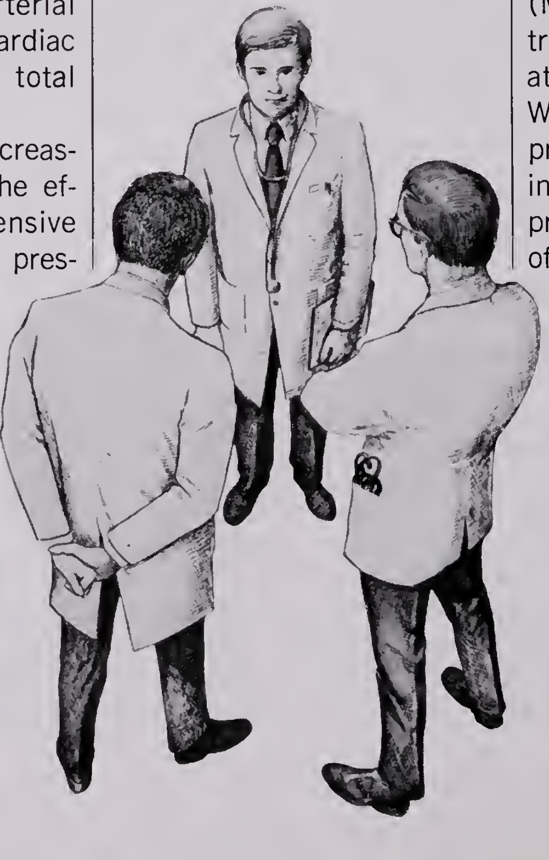
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

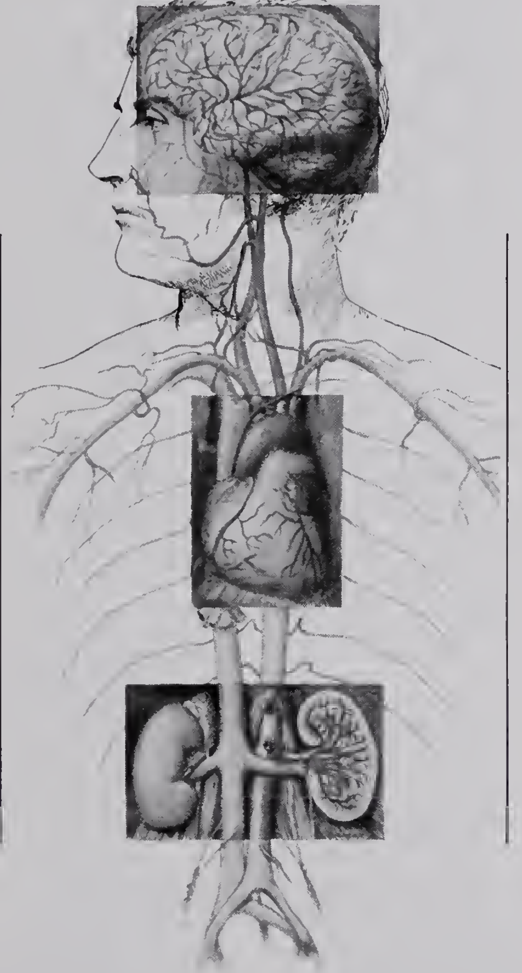
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®
(METHYLDOPA | MSD)

smoothly lowers blood pressure

For a brief summary of prescribing information,
please see following page.

NEW
now available in
500 mg TABLETS
as well as the standard
250-mg tablets

In most cases of
sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

addendum

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LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

The death of Mme. Marie Curie on July 4, 1934 marks the passing of one of the world's most noted scientists. Born of a scholarly family in Warsaw, Poland on Nov. 7, 1867, she inherited the necessary aptitude for teaching and scientific investigation. Following her elementary school education, she went to Paris at the age of 24 to enter the University under Becquerel, professor of physics. It was he who, in 1896, discovered radioactivity in the element uranium which he isolated from pitchblend.

About two years after her graduation, she met M. Pierre Curie who had just been made professor in the School of Physics and Chemistry of the City of Paris. The first fruit of their efforts was the discovery in July, 1898 of the new radioactive element, polonium, which was named after Mme. Curie's native land. This was followed a few months later by the announcement of the discovery of another much more powerfully radioactive element, radium.

The discovery of these new elements was only the beginning of the scientific research work necessary in determining their physical properties and the peculiarities of the new form of radiant energy. Alas, this had to be carried on in large part by Mme. Curie alone, owing to the untimely death of her husband, Pierre, who was run down and killed by a truck on the Paris streets in 1906.

True to her original trust, Mme. Curie continued in the field of research at the Curie Institute in Paris until the time of her death. Many honors were bestowed upon her. She was twice the recipient of the Nobel Prize, once alone and once in association with M. Curie and M. Henri Becquerel.

TWENTY-FIVE YEARS AGO

The Kansas City Southwest Clinical Society will present its 27th Annual Fall Clinical Conference on October 3-6. The four days will include scientific presentations, a clinicopathologic conference, a citizen-physician problem conference, daily round table luncheons with question-and-answer periods, scientific and technical exhibits, motion pictures and entertainment. Appearing on the program will be Drs. Edgar V. Allen, Rochester; R. W. Danielson, Denver; Aubrey Hampton, Washington; Lewis M. Hurxthal, Boston; Frank Lahey, Boston; Virgil H. Moon, Winston-Salem; Walter L. Palmer, Chicago; John L. Parks, Washington; I. S. Ravdin, Philadelphia; Harry E. Bacon, Philadelphia; Grayson L. Carroll, St. Louis; O. T. Clagett, Rochester; and Wolfgang W. Zuelzer, Detroit.

Melvin A. Casberg, M.D., has been appointed dean of the St. Louis University School of Medicine and assumed his duties on August 1. Dr. Casberg graduated from the school in 1936.

Orr Mullinax, M.D., has been appointed superintendent of State Hospital #2 at St. Joseph. Dr. Mullinax has maintained his residence in St. Joseph during the time he served as director of the Division of Mental Diseases in Jefferson City.

W. O. Finney, M.D., Chaffee, was elected president of the State Board of Medical Examiners at a meeting on July 31. Edwin C. Schmidtke, M.D., Columbia was elected vice-president and W. L. Brandon, M.D., Poplar Bluff, was elected secretary-treasurer.

TEN YEARS AGO

An average of more than $1 million a month was paid in medical-surgical benefits by the St. Louis Blue Shield Plan during the fiscal year ending on April 30, it was announced at the 19th annual meeting of the Blue Shield voting board held in St. Louis on June 28. Dr. R. O. Muether, president of St. Louis Blue Shield, reported that a total of $12,181,309 was distributed in benefits during the year. This is the first year in the Plan's history that payments for services to members reached the $1 million per month average, Dr. Muether said. A St. Louis physician, Dr. Muether was reelected president of St. Louis Blue Shield at the meeting. Other officers reelected were Dr. Ben M. Bull, Ironton, first vice-president, and Dr. Leo J. Hartnett, St. Louis, second vice-president.

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To work in the St. Louis County Department of Community Health and Medical Care directing a major phase of a public health program which includes the following areas: communicable diseases such as T.B., V.D., and miscellaneous diseases (measles, smallpox, etc.); immunization and epidemiology.

The St. Louis County Department of Community Health and Medical Care represents a new concept in health care service where previously established departments of Health and Hospital were combined the latter part of 1973 to achieve an overall, comprehensive planned health care system to serve a population of over 950,000 in an area of over 500 square miles. It is designed to bring together the generally specialized health care resources in the areas of public health and preventative, curative, and rehabilitative medicine and to eliminate the duplication of many services normally found in separate hospital and health facilities.

Successful applicants must possess an M.D. degree and considerable administrative and professional experience in public health work. Salary range is $25,525-$32,574.

Interested persons should send a complete resume to the Division of Personnel, 7900 Forsyth, 7th Fl., Clayton, Mo. 63105 or call 314-889-2429 for an application.

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Previous industrial experience desirable, but not mandatory. Please send resume, with minimum salary requirements, in confidence, to: Box 399, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101.

Before prescribing, please consult iplete product information, a summary hich follows:

Indications: Relief of anxiety and ion occurring alone or accompanying ous disease states.

Contraindications: Patients with known ersensitivity to the drug.

Warnings: Caution patients about sible combined effects with alcohol and er CNS depressants. As with all -acting drugs, caution patients inst hazardous occupations requiring iplete mental alertness (*e.g.*, oper- g machinery, driving). Though physi- and psychological dependence have ly been reported on recommended es, use caution in administering to iction-prone individuals or those who ht increase dosage; withdrawal symp- is (including convulsions), following continuation of the drug and similar hose seen with barbiturates, have been orted. Use of any drug in pregnancy, ation, or in women of childbearing requires that its potential benefits weighed against its possible hazards.

Precautions: In the elderly and de- tated, and in children over six, limit to allest effective dosage (initially 10 or less per day) to preclude ataxia or rsedation, increasing gradually as ded and tolerated. Not recommended hildren under six. Though generally recommended, if combination therapy other psychotropics seems indicated, efully consider individual pharmaco- ic effects, particularly in use of poten- ing drugs such as MAO inhibitors phenothiazines. Observe usual precau- is in presence of impaired renal nepatic function. Paradoxical reac- is (*e.g.*, excitement, stimulation and ite rage) have been reported in psychi- c patients and hyperactive aggressive ldren. Employ usual precautions in treat- nt of anxiety states with evidence of pending depression; suicidal tendencies y be present and protective measures essary. Variable effects on blood gulation have been reported very rarely patients receiving the drug and oral icoagulants; causal relationship has been established clinically.

Adverse Reactions: Drowsiness, xia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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for summary of product information.

Missouri Medicine

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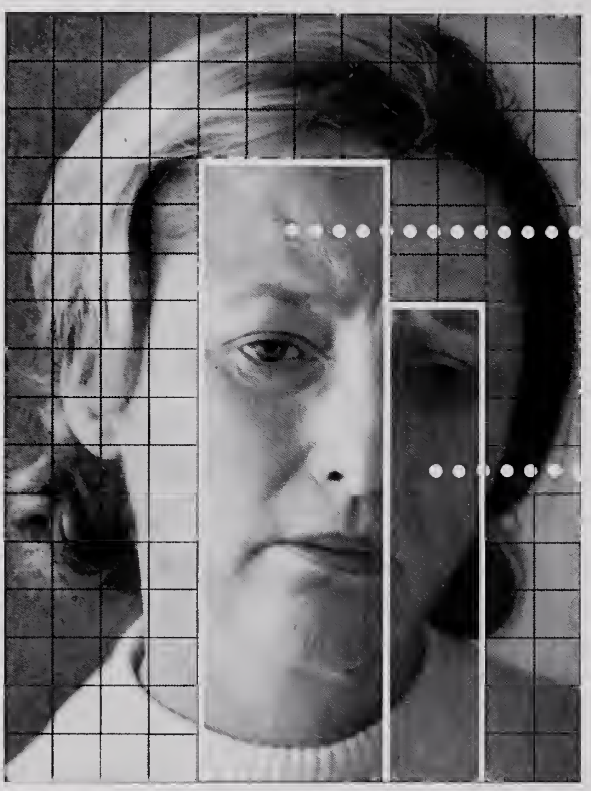
117th MSMA Annual Session
April 17-20, 1975, St. Louis

Both often


Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in freq and/ or severity of grand mal seizures require increased dosage of standard convulsant medication; abrupt withd may be associated with temporary increase in frequency and/ or severity c seizures. Advise against simultaneou gestion of alcohol and other CNS dep sants. Withdrawal symptoms (simila those with barbiturates and alcohol) occurred following abrupt discontinu (convulsions, tremor, abdominal anc cle cramps, vomiting and sweating). addiction-prone individuals under ca

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According to her major
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provide relief for both—as
excessive anxiety is re-
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s associated with it are also
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s rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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in psychoneurotic
anxiety states
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ring age, weigh potential benefit
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cautions: If combined with other psy-
tropics or anticonvulsants, consider
fully pharmacology of agents em-
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cotics, barbiturates, MAO inhibitors
other antidepressants may potentiate
ction. Usual precautions indicated in
ents severely depressed, or with latent
ression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Missouri Medicine

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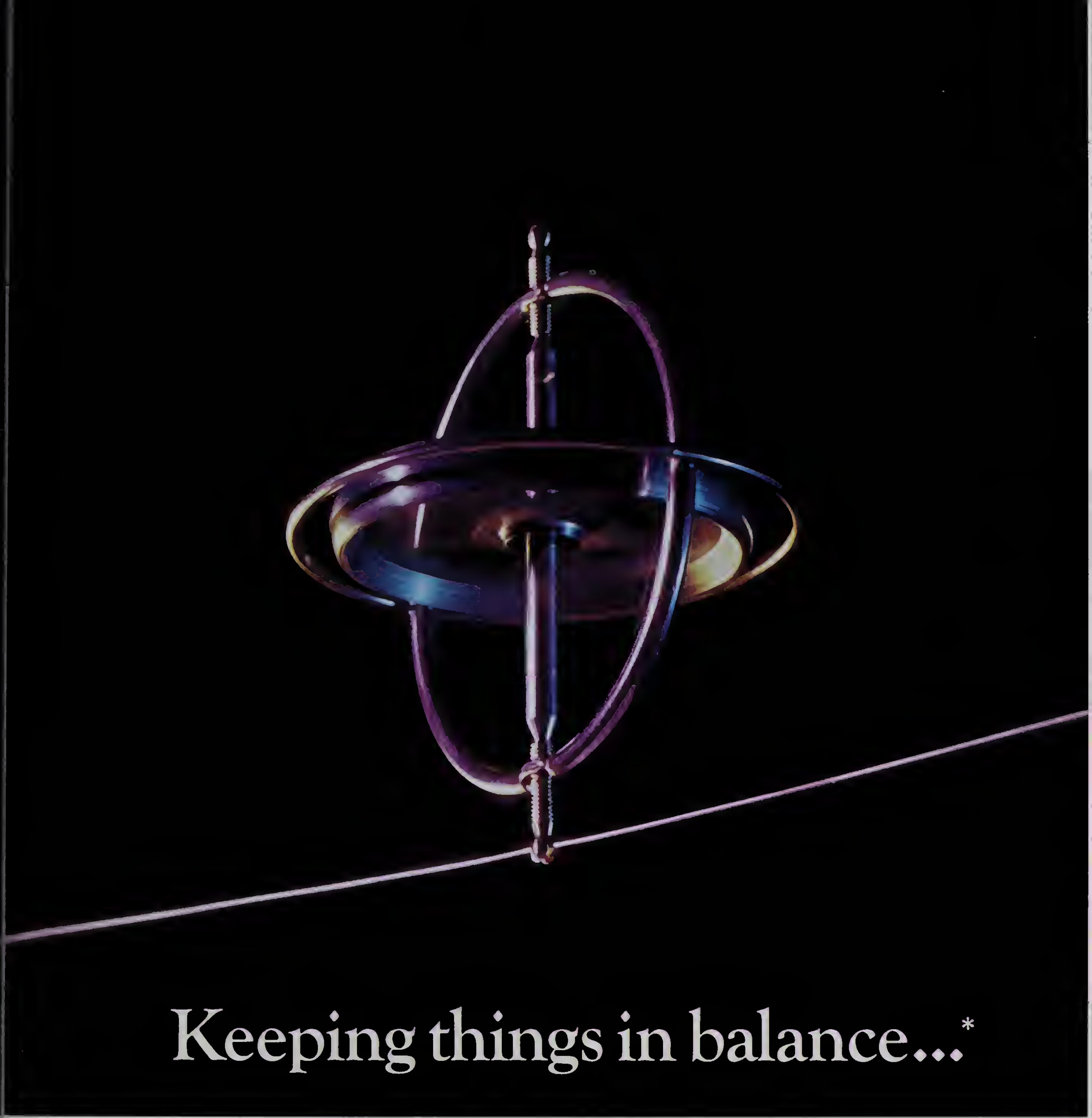

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Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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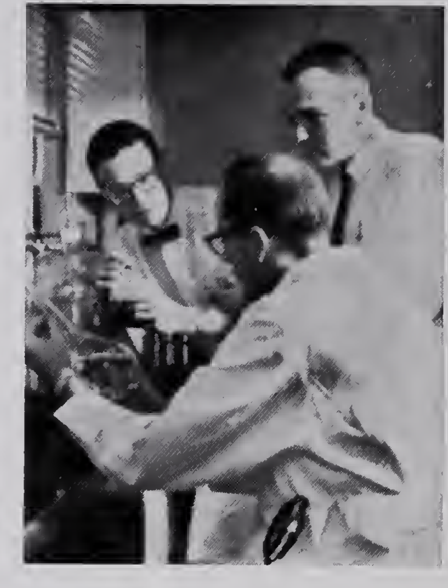

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MSMA NEWS ROUND-UP

October, 1974

Council hears preliminary report

rofessional liability insurance study continues

A preliminary report on a proposed state-wide professional liability insurance program for MSMA members was accepted by the Association Council at its meeting in Kansas City, Sept. 13-14.

The Rollins Burdick Hunter Company, which has been studying the professional liability insurance situations in Missouri, was requested to continue to evolve a program in conjunction with the MSMA Ad Hoc Committee on Professional Liability Insurance, chaired by Dr. Irving H. Clark of Kansas City. Further information will be furnished to the Council at a later meeting.

The Council also accepted the report of the Committee on Planning which:

1) Called for development of recognition awards for MSMA outgoing officers and councilors, AMA delegates and alternates and committee and commission members.

2) Requested the Committee on Arrangements for the 1975 Annual Session to consider changing the format of the Annual Banquet by transferring the recognition of Past Presidents and 50-Year Members to the Saturday general luncheon.

3) Recommended the mailing of an MSMA Policy Manual to each Association member and to update the Manual annually.

4) Directed staff to develop hard proposals for the possible use of computer services at Headquarters and to study the feasibility of installing inward and/or outward WATS lines.

5) Suggested that MSMA Vice Presidents should be utilized by the President in carrying out Association business.

Continued on Next Page

Don Wilson .... Field Secretary

Field Secretary will expand services to MSMA members

Following the directive of the 1974 House of Delegates which called for expanded services to MSMA members, Don Wilson has been employed as MSMA Field Secretary.

Don will devote much of his time to consultations with County Medical Society officers and MSMA members throughout the state. His prime responsibility will be to keep MSMA members informed on current information and services available from MSMA Headquarters and AMA Headquarters. In turn, he will convey the input of County Societies and members back to MSMA Headquarters regarding Association policies and services.

As liaison man between MSMA members, County Societies, and Headquarters, Don will be available to assist in developing local programs, obtaining specialized speakers and providing a "direct line" of communications within the structure of the Association.

Many MSMA members have previously met Don during his 10 years of work in the health care field which he began in 1964 as Regional Consultant for the Missouri Heart Association in Northwest Missouri.

In 1968 he became Research Coordinator for the Missouri Heart Association, Missouri Region-

Continued on Next Page

Physicians get turn to vote for medicine on Tuesday, Nov. 5

It is often stated that "the public" is demanding a change in the health care system of this country. However, when we read surveys which show that health care problems rank 18th in a list of current concerns expressed by "the public," it is evident the demand for change comes from another source — government leaders!

Perhaps one of the kindest statements medicine can say about government lately is that elected officials still have to come before the voting public at regular intervals. The next interval is **Tuesday, Nov. 5.**

In Missouri, one U.S. Senator, 10 U.S. Congressmen, the State Auditor, 17 State Senators, 163 State Representatives and numerous local officials will be elected on Nov. 5.

With the support of many, many physicians from across the state, the Missouri Medical Political Action Committee (MMPAC) has provided financial assistance to the campaigns of those candidates who have indicated "a willingness to listen to medicine's point of view on important issues." This does not mean that, if elected, these candidates will always vote the way medicine feels, but it does provide medicine's representatives the opportunity to present their opinions.

But MMPAC, regardless of the great success it has exhibited the past several elections, still cannot **elect** *candidates! Only the voters can do that . . . and each Missouri physician and his family should make sure that their ballots are cast for the candidates of their choice on Nov. 5.*

Have your secretary mark Election Day on your appointment book **now!** *Then, on Nov. 5, take time to vote and encourage your office staff to go to the polls.*

With national health insurance, PSRO regulations, manpower bills and threats of even more tighter control over medicine certain to come before the state and national governing bodies in the next year, each Missouri physician must utilize his or her most powerful right — the right to cast his convictions at the Ballot Box!

Amalgamation vote set

Members of the St. Louis City Medical Society and St. Louis County Medical Society will cast ballots for possible amalgamation of the two societies on Tuesday, Oct. 15.

Following an AMA survey of the two societies a year ago which recommended amalgamation, the societies formed a Joint Committee to investigate the feasibility of combining. The Executive Councils of both societies have voted for amalgamation.

Council action

Continued

Several other items of importance were considered by the Council. These included:

- Discussion of a Health Manpower Study project being conducted under the direction of the state Comprehensive Health Planning Agency. An MSMA Ad Hoc Committee will be appointed to review the project results.
- Referral of a St. Louis physician's problem dealing with retroactive denial of payments by Medicare to the Commission on Medical Economics, Third Party Medicine and Governmental Relations.
- **An explanation of a proposal by the Missouri Division of Health for collection of hospital discharge data. Dr. Herbert Domke, Division Director, assured the Council that confidentiality of records would be preserved.**
- Formation of an Ad Hoc Committee on National Health Insurance to work with the AMA in informing physicians and the public about the various NHI plans.
- Endorsement of recommendations from the Legislative Committee which included the request that the Board of Healing Arts reaffirm its position on the practice of acupuncture.
- Acceptance of a report from J. Loren Washburn, M.D., AMA Delegate, on the 1974 AMA Annual Session in Chicago.
- Endorsement of the Travel Committee's recommendation of two MSMA-sponsored trips in 1975: a 14-day trip to Africa in February and a trip to Canada and Alaska in August or September.
- **Acceptance of a report from the Commission on Medical Economics, Third Party Medicine and Governmental Relations which included the recommendation to appoint an Ad Hoc Committee to investigate any disproportion of fees paid under Medicaid.**
- Reports from the four medical schools in Missouri which indicated a total of 453 students have been enrolled in the first year of medical school. The breakdown is St. Louis University 151, Washington University 120, Missouri University-Columbia 110, and Missouri University-Kansas City 72.

Field Secretary

Continued

al Medical Program and Missouri Division of Health. His objectives in this position were to promote more active participation by Missouri physicians in the Division of Health's free primary and secondary rheumatic fever prevention programs and to evaluate the effectiveness of "person-to-person" contact with physicians regarding health programs compared with previous vehicles of communications such as letters, newsletters, etc.

In 1970, Don assumed the position of Assistant to the Director of Operations for the Missouri Regional Medical Program. Since August, 1973, he has been Northwest Missouri Area Executive Director for the American Cancer Society.

Immunization Action Month is endorsed

Immunization Action Month-1974 will be conducted during October. IAM-1973 received the endorsement of the MSMA and the AMA. The 1974 campaign again received the backing of the AMA at the June Convention.

The Council of the MSMA unanimously endorsed the 1974 campaign and authorized the Executive Secretary to join with Gov. Christopher S. Bond in declaring October as IAM-74 Month.

Immunization Action Month-1974 is a cooperative effort to reverse the declining trend of immunization levels, particularly among pre-school children, against poliomyelitis, measles, rubella, mumps, pertussis, tetanus and diphtheria.

In 1972, 62.9 percent of children 1-4 years of age were immunized against poliomyelitis; in 1973, only 60.4 percent were so immunized.

The comparable data for measles are 62.2 percent in 1972 and 61.2 percent in 1973; for rubella 56.9 percent in 1972 and 55.6 percent in 1973; and for DPT 75.6 percent in 1972 and 72.6 percent in 1973. In 1973, only 34.7 percent of the children 1-4 years of age had been immunized against mumps.

Sponsored and coordinated by the Center for Disease Control, Immunization Month involves the active participation of several national medical and health organizations, a number of pharmaceutical companies and voluntary action groups.

In an effort to increase levels of immunization against preventable diseases, physicians have been requested to audit the records of their pre-school patients to insure that they have been immunized.

During the next two months, a nationwide campaign will be conducted to motivate parents to bring their inadequately immunized children to public or private medical officials for immunizations between October 1974 and October 1975.

Immunization guidance booklet now available to Missouri physicians

The Missouri Division of Health has assembled an immunization guidance booklet for the information and use of the practicing physicians and health professionals in the state.

The materials pertaining to specific vaccines were first published by the Center for Disease Control in June 1972 as the "Collected Recommendations of the Public Health Service Advisory Committee of Immunization Practices" and remains current and valid (including all 1973-74 revisions).

The "Regulation Governing Immunization of School Children" (Rev. 1973) and the "Missouri State Law Regarding Immunizations" (Rev. 1973) are also included in this booklet.

If a copy of the **Missouri Physicians Immnization Handbook** is desired, please write to the Missouri Division of Health, 309 Adams Street, Jefferson City, Missouri 65101, or telephone 751-2782, 751-2868, or 751-3751.

News-in-Brief

Crippled Children's Service

Dr. R. C. Arnold has announced his retirement as Director of the Missouri Crippled Children's Service effective Sept. 30, 1974.

The Division of Health has announced that a search committee has been appointed to assist in finding a successor for Dr. Arnold.

Committee members are John Barnard, M.D., Kansas City; John T. Crowe, M.D., Cape Girardeau; Charles Cline, D.O., Kirksville; Francis X. Lieb, M.D., St. Louis; and Mr. Linn Perkins, St. Louis Children's Hospital.

Under the recent reorganization of state government, the Missouri Crippled Children's Service was shifted from the University of Missouri to the state Division of Health.

Two named to Board

Two new members were recently named to the Board of Registration for the Healing Arts by Gov. Christopher S. Bond.

Joseph S. Cope, M.D., Lexington, and John N. Martin, M.D., St. Joseph, are the new members. They replace Shelby Hughes, M.D., Clinton, and William W. Monafo, M.D., St. Louis.

Dr. Wilson appointed

Vernon E. Wilson, M.D., professor of community health and medical practice at the University of Missouri-Columbia, will be appointed Vice-Chancellor for Medical Affairs at Vanderbilt University effective Nov. 1.

Dr. Wilson is a former dean of the M.U.-Columbia School of Medicine and in 1968 became the first UMC vice-president for academic affairs. He was Administrator, Health Services and Mental Health Administration, U.S. Department of H.E.W. from 1970 to 1973.

Who said that?

"We must now turn our attention to the even more important task of selecting the drug that should appropriately be dispensed."

Sound like a logical statement of a conscientious physician? Wrong!

The above quote was taken from the inaugural address of Robert C. Johnson, new president of the American Pharmaceutical Association, as published in the September 1, 1974 edition of **American Druggist**.

Mr. Johnson declared: "The battle on drug product selection is nearly over. Even some of the most bitter opponents are privately conceding that pharmacists will select, and in fact are selecting, the brand of a drug to be dispensed."

To accomplish the task of appropriate drug selection as mentioned, Mr. Johnson says the APHA will have to wage a vigorous battle. "But wage it we will — for the health of the citizens of this country depend on it."

Mr. Johnson also stated that: "the American Medical Association and related medical associations prevent the selection of drug products on the basis of reasonable cost. It is organized medicine that continues to defend the irrational prescribing habits of physicians."

Missouri physicians receive AMA Recognition Award

The recently released list of recipients of the 1973 AMA Physician's Recognition Award included 177 Missouri doctors.

The award is to recognize, encourage and support physicians who participate in continuing medical education and to emphasize the need to develop more meaningful CME opportunities.

The AMA Award is granted to physicians who complete a minimum of 150 credit hours of CME over a three-year period. Applications for the award are sent out every three years by the AMA. This year, by mistake, the AMA sent some 1973 recipients an application for the 1974 award. These applications should be disregarded. 1973 recipients will be sent another form in 1976.

The following physicians received the 1973 award:

Drs. Andres G. Apostol, *Monett;* Thomas W. Carroll, *Lamar;* Sylvan Bartlett, David H. Davis, Corinne Farrell, Mujtaba Husain, Charles E. Mengel, Heidar Nematolahi, Alan E. Oestreich, Salim B. Saab, David G. Schrunk, and Ruben A. Ungaro, *Columbia;* Gary A. Dyer, *St. Joseph.*

Drs. Fereydoon Adibi, Fred Caldwell, Emilio M. Canlas, Richard A. Fraser, Eugene T. Hansbrough, Devendra K. Varma, and Thomas O. Wood, *Popular Bluff;* Richard A. Osbourn, *Fulton;* Melvin R. Hayden, *Camdenton;* E. Warren Allen, *Carrollton;* Phillip E. King, *North Kansas City.*

Drs. William D. Soper, *Excelsior Springs;* Lawrence E. Giffen and Andrew M. Giuliani, *Jefferson City;* Pin H. Pu, *Kennett;* Paul A. Brenner, *Owensville;* George M. Workman, *Hermann;* Lanny R. Brent, Durward G. Hall, Henry C. Krahn, John F. Patterson, Rhodes W. Quisenberry, and Richard L. Smith, *Springfield.*

Drs. Amos L. Coffee, *Willow Springs;* V. Dale Alquist, John E. Burch, and Edward M. Grim, *Joplin;* Walter T. Judge, *Crystal City;* Dennis E. Hite, *Lebanon;* Gretchen D. Collins, *Macon;* Wyeth Hamlin and Hiremathada Jayanandaiah, *Hannibal.*

Drs. Paul W. Pendell, *Rolla;* Laurence D. Cohen, James A. D'Antonio, W. Rex Davis, David B. MacMillan and Robert H. Mosebar, *Fort Leonard Wood;* Thomas B. Cook, *Richmond;* Lawrence W. Keefe and Ronald B. Rice, *St. Charles.*

Drs. Ale R. Shreim, *Sikeston;* James W. Crain, *Branson;* Raphael J. Torontow, *Nevada;* Kirby L. Turner, *Potosi;* William J. Beard, *Lee's Summit;* David F. Eubank, *Raytown;* Charles E. Nickson and Steven J. Soper, *Independence.*

Drs. Gamaliel P. Abaqueta, William B. Barry, Maxwell G. Berry, William H. Bryan, Virgilio R. Castillo, George S. Devins, George D. Dixon, Ramon R. Dy-Ragos, Gustave Eisemann, Fred A. Fayne, Roy F. Garrison, John M. Haight, Donald E. Kuenzi, Jon R. Leach, Alexander G. Mallouk, Martin J. Mueller, Robert G. Muth, Huseni E. Poonawala, A. Lester Saferstein, Pu Shu, Weldon L. Sportsman, Edward H. Stratemeier, Harvey Thalblum, Fred A. Thomas, Bennie J. Throne, Barnard C. Trowbridge, Nancy Waldman, Morris F. Wise and R. Paul Wright, all of *Kansas City.*

The following physicians from the *County of St. Louis.*

Jorge M. Alegre, Robert E. Burdge, Fritz A. Byrum, Jack Cokrhame, Robert J. Corday, Tony M. Deeths, Stephen L. Hantman, John A. Headrick, H. Frank Holman, Bruce J. Hookerman, Max M. Inman, Chung H. Khan, Chung Ki Kim, Don G. Livingston, Joseph D. Marco, Harry A. McLean, Karen L. Moritz, John P. Murray, Lon W. O'Bannon, Frank Ostapowicz, Paul F. Palmberg, Roman Lee Patrick, and Vincent P. Perna.

The following physicians from the *City of St. Louis.*

Donald C. Anderson, Alma A. Apostol, Madhu G. Bahl, Stephen F. Bowen, Daniel J. Brennan, Samuel A. Canaan, John A. Carrier, Melvin A. Cassel, Roberto P. Coquis, Reno R. Cova, Gloria De Garcia, James M. Epstein, Jack M. Estes, Frank W. Farrell, Patrick J. Gannon, Alicia D. Gonzalez, Rudolf H. Good, Wayne O. Gorla, John G. Gregory.

Alex Harell, Jack Hartstein, Joseph C. Heffernan, James H. Hutchinson, Olawale O. Idewu, Mitsuo Kitahara, Edward H. Kowert, Norton S. Kronemer, Siriporn Kulkamthorn, Sripatt Kulkamthorn, Weerapan Kuyakanon, Abdul S. Lalani, Virginia L. Larsen, Sung R. Lee, Chester P. Lynxwiler.

Richard L. McDowell, Joseph P. McEnery, Manorama Mohapatra, Raj N. Mohapatra, Raymond O. Muether, Delfin T. Nieva, Dennis M. O'Connor, Donald L. Oetter, Fletcher T. Ott, Prabha Partap, Richard L. Payne, William J. Phillips, Leonard N. Piccione, Lourdes C. Pineda, Morris W. Pulliam.

Abelardo B. Sanchez, Earl R. Schultz, Federic M. Simowitz, Hugh R. Smith, Charles R. Stephen, Pedro L. Suarez-Solar, Kongsak Tanphaichitr, Thomas R. Thale, Manfred Thurmann, Manu Tongwarin, Irl G. Tremain, M. Luis Tumialan, Gianfranco Turati, Somsak Vongratanato, Jacob T. Wilensky, and Fazle M. Yasin.

'Good Samaritan' section termed unconstitutional

The "Good Samaritan" section of the Ambulance Bill passed by the Missouri General Assembly in 1973 has been termed unconstitutional by Attorney General John Danforth.

In issuing the opinion, the Attorney General's office said that Section 20 (Good Samaritan) of the Ambulance Bill was not covered in the title of the bill and, therefore, is contrary to the Missouri Constitution.

Section 20 read "any person who has been trained to provide first aid in a standard, recognized training program may render emergency care or assistance to the level for which he or she has been trained, at the scene of an emergency or accident, and shall not be liable for civil damages for acts or omissions other than damages occasioned by gross negligence or omissions by such persons in rendering such emergency care."

In another opinion concerning the Ambulance Bill, the Attorney General stated that a person applying for a license as an ambulance attendant-driver need be only 18 years of age, not 21 years old as the bill reads.

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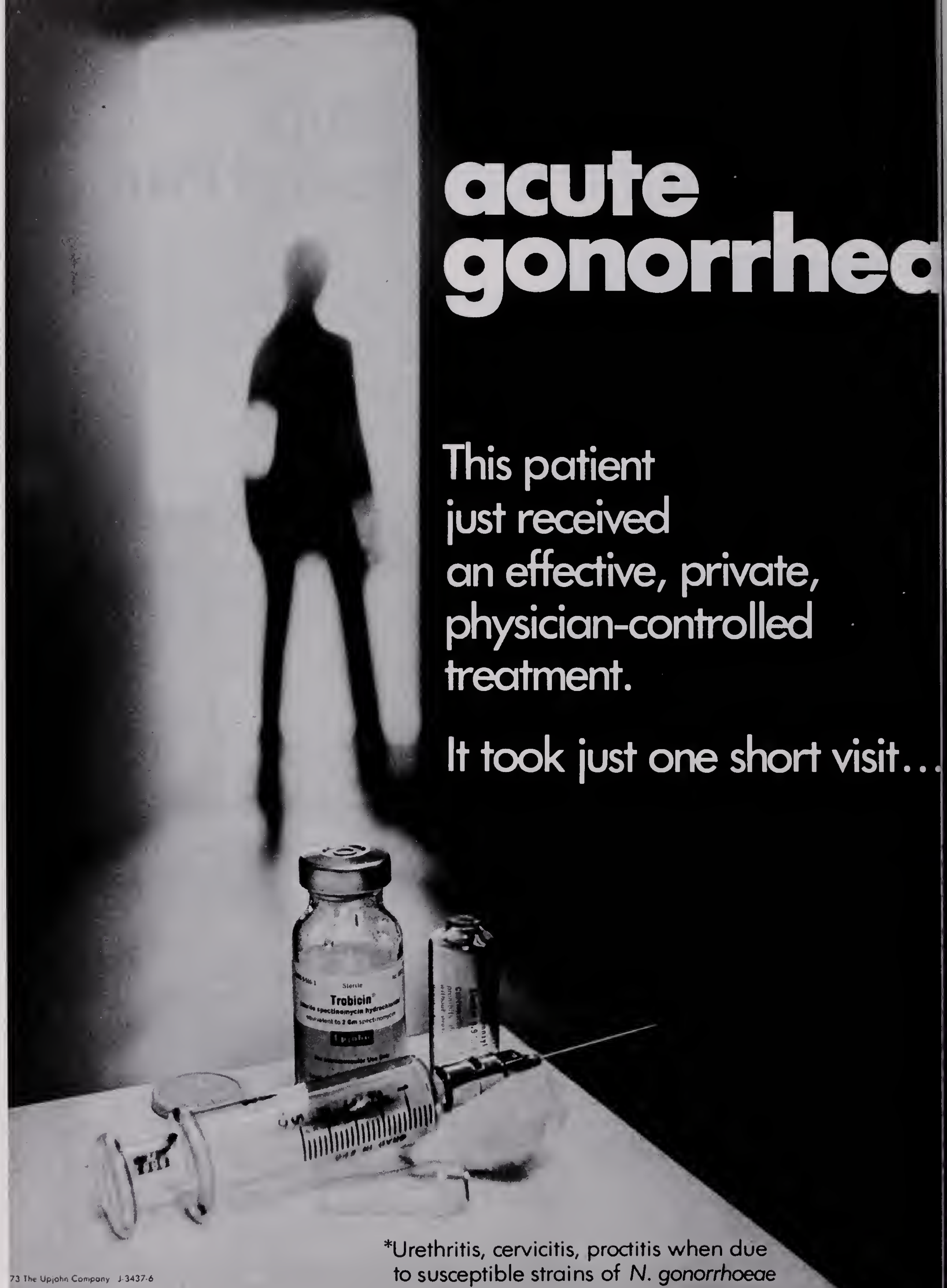

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It took just one short visit…

*Urethritis, cervicitis, proctitis when due
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There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly[†]; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

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t strains of *Neisseria gonorrhoeae* (MIC 7.5
0 mcg/ml). Definitive *in vitro* studies have
wn no cross resistance of *N. gonorrhoeae*
veen spectinomycin and penicillin.

ications: Acute gonorrheal urethritis
proctitis in the male and acute gonorrheal
icitis and proctitis in the female when due
usceptible strains of *N. gonorrhoeae*.

ntraindications: Contraindicated in pa-
ts previously found hypersensitive to spec-
mycin.

rnings: Not indicated for the treatment of
hilis. Antibiotics used to treat gonorrhea
mask or delay the symptoms of incubating
hilis. Patients should be carefully examined
monthly serological follow-up for at least
onths should be instituted if the diagnosis of
syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—**Inject 5 ml intramuscularly** for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—**Inject 10 ml intramuscularly** for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
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[†] or patients with gonorrheal proctitis and for patients in geographic areas where antibiotic
sistance is known to be prevalent, initial treatment with 4 grams is preferred.

Pension Legislation: Its Effect on Physicians

By

THOMAS F. EAGLETON
United States Senator
Washington, D. C.

The following informational article on H.R. 2, the national pension reform bill, was written by Senator Eagleton for Missouri Medicine.

The national pension legislation, known as H.R. 2, will affect all private pension plans. Generally, it will require the vesting of pension benefits, the actual funding of such plans over a specified period of time and the establishment of a user-financed, government-run insurance program to protect employees against failing pension plans. It also will liberalize the rules on pension plans set up by individuals who are in business for themselves . . . the so-called Keogh retirement plans.

While there may be some in the medical profession who are involved in professional corporations, I would guess that most doctors, like most lawyers, are either self-employed as individuals or are involved in partnerships which for tax purposes have the same effect. I, therefore, will review the probable changes in Keogh plans which H.R. 2 will make.

Beginning this year, instead of the lesser of $2,500 or 10% of wages, which has until now been deductible from the income of a self-employed person if that amount were set aside in an approved Keogh plan, H.R. 2 will authorize the setting aside of the lesser of $7,500 or 15% of earned income each year as deductible from the income of a self-employed person.

As before, if an individual sets up a Keogh plan for himself and has one or more employees who work for him full time, he must include those employees in the retirement plan if they have worked for him three or more years. This means that if you, as a self-employed individual, want to set aside the maximum amount allowable, you must set aside an equal percentage of your employees' incomes for their future retirement. However, it should be noted that these expenditures for your employees are tax deductible as a business expense.

What are the advantages of a Keogh plan? Why are the changes in Keogh plans important to the average professional doctor, lawyer, accountant or businessman? The basic advantage is the transfer of income tax liability from years of high income to years when earnings are potentially less. First, the money placed in such a plan is not taxable in the year earned and placed in the plan. Second, the build-up of interest or dividends on the accumulated amount in the plan also remains tax-free from year to year until the plan matures at retirement. Therefore, just as with the pension plan set up by a large corporation, an individual who has set up a Keogh plan can set aside savings for his future needs without having to pay part of these earnings to the government.

When can an individual who has contributed to a Keogh plan get the benefits of his savings? Normally, a person cannot without penalty draw on these funds until he has reached 59½ years of age, and he must draw on these funds prior to 70½ years of age. If drawing is made earlier than 59½ years, an additional tax of 10% will be levied on the distributed amount. Likewise, an excise tax of 6% will be imposed on contributions above those allowed.

One final limitation is contained in the legislation. Maximum yearly benefits are limited to the lesser of $75,000 or 100% of a participant's average salary during his highest three consecutive years of compensation. The stating of this limitation clearly indicates the advantages of the newly expanded Keogh plans. It allows a self-employed individual to establish a tax deductible plan to safeguard his years of retirement.

in Brief

A summary of AMA, medical & health news

American Medical Association / 535 North Dearborn Street / Chicago, Illinois 60610 / Phone (312) 527-1500/TWX 910-221-0300

The AMA is offering two "firsts" in postgraduate courses, beginning with the Clinical Convention in Portland, Ore. Scheduled for November 30-December 1, a postgraduate course in public speaking will cover the basic speaking skills offered in the regular AMA speakers' programs, plus personal coaching and evaluation through television playbacks. The course provides 11 hours of Category I credit toward the AMA's Physician's Recognition Award. Also offering Category I credit will be new courses, co-sponsored by the AMA and state medical societies and offered as regional programs. They are designed for physicians who do not attend AMA Annual or Clinical Conventions.

The Joint Commission on Accreditation of Hospitals' Board of Commissioners has expanded due-process provisions for physicians employed by hospitals in medical-administrative positions. Under the new policy, a physician or dentist who is being terminated has the right to a hearing before a joint conference of hospital governing board representatives and representatives selected by the voting members of the medical staff. The change in the interpretive material of Standard VIII of the "Governing Body Management" section of the JCAH *Accreditation Manual for Hospitals,* is expected to restrict arbitrary action in the termination of salaried chiefs of services and other physicians in medical-administrative positions.

An **open hearing** on the AMA's Section Councils will be conducted by the Council on Constitution and Bylaws on November 30 during the 1974 Clinical Convention.

Coverage for chiropractic services under Medicare will not be expanded. HEW issued final regulations limiting a chiropractor's activity under law. Coverage will be provided only for treatment of "subluxation" when "a malpositioning of a vertebra (is) anatomically demonstrable on an x-ray film." Chiropractors will not be paid for diagnostic x-rays.

AMA **computer services** available to state and medical specialty societies under AM-CAP—American Medical Computer Services—are detailed in a booklet prepared by the AMA's Dept. of Data Services. Societies may obtain a copy from Dept. of Data Services, AMA Headquarters.

A **three-year, experimental** citywide prepaid health system under Medicaid will be launched in Newark, N. J. Between $36 million and $54 million in federal and state money will be spent on the project. The plan will reorganize the existing health facilities in Newark into one system of care, available on a prepaid basis. Six hospital clinics and six neighborhood health centers are participating in the program. The majority of physicians in the city have formed an independent practice association that will provide private doctors' services in the same prepaid way.

Acceptance of foreign medical graduates by all U. S. training hospitals was urged by the AMA's Committee on Housestaff Affairs. The committee issued a report with 45 separate recommendations advocating the "elimination of double standards, discriminatory requirements and other pernicious policies. . . ." The report will be forwarded to the AMA's Board of Trustees to be included in the Board's report to the Clinical Convention in December.

Non-profit hospitals are no longer exempt from the National Labor Relations Act. The new law includes a provision for a 30-day fact-finding period prior to the end of negotiations on contracts. The American Hospital Association had advocated a 60-day cooling-off period beginning at the end of contract negotiations.

Three upcoming AMA courses and conferences at the Marriott Motor Hotel in Chicago are Financial Management Seminar, November 2-3, contact Practice Management Section, AMA Headquarters . . . AMA Speakers and Leadership Program, November 16-17, contact AMA Speakers and Leadership Programs, AMA Headquarters . . . 3rd AMA National Leadership Conference, January 24-26, 1975, contact Field Service Dept., AMA Headquarters.

medical melange

Notes of interest from Here . . . . and There

Dr. Wilma W. Claseman has been appointed assistant health commissioner in charge of the Bureau of Communicable and Reportable Diseases of the city of St. Louis. The appointment was announced by **Dr. Helen L. Bruce**, health commissioner. Dr. Claseman joined the health division staff as a school physician in 1962 and was appointed the medical chief of the school health service in 1971, a position she has held until her present appointment.

Dr. Ned W. Smull, Kansas City, will retain his position as chairman of pediatrics and director of Children's Mercy Hospital as well as assume the office of Vice-Provost for Health Sciences at the University of Missouri-Kansas City. As Vice-Provost, Dr. Smull will be the administrative coordinator of UMKC's schools of medicine, pharmacy and dentistry and the graduate school of nursing.

Dr. Raymond A. Christy, Springfield, has been chosen to receive the 1974 Clifford G. Grulee Award for service to the American Academy of Pediatrics. He was chosen because of his contribution to child health through the development of two manuals on child health care. The award will be presented to Dr. Christy at the annual meeting of the AAP in San Francisco on October 20.

Dr. Harold P. Robb, director of the Missouri Department of Mental Health, was the guest speaker at the first annual meeting of the Lakes Country Task Force on Alcoholism and Related Problems in Springfield on September 18.

Dr. Ronald James of the University of Missouri-Columbia Medical Center staff presented the program at the meeting of the Mexico Regional Diabetes Association on September 11. His topic was "Chronic Complications of Diabetes."

Dr. Helen Nash, St. Louis, has donated a month of time in the Philippines to help prepare a staff for children's health clinics there. The project emphasizes education for mothers with children under five years of age on Luzon Island. It also is trying to introduce measures in community development, nutrition, sanitation, family planning, agriculture and general health education.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try Dimetapp Extentabs®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or

Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammation, edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS *Use in children:* In infants [illegible]
PRECAUTIONS [illegible]

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Phenaphen with Codeine No 2, 3, or 4 contains: Phenobarbital (¼ gr), 16 2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162 0 mg; Phenacetin (3 gr.), 194 0 mg; Codeine phosphate, ¼ gr (No. 2), ½ gr. (No. 3) or 1 gr (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

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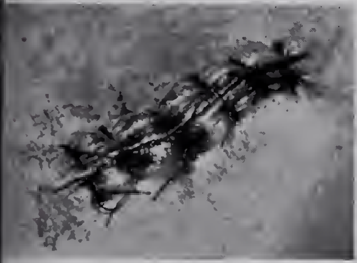

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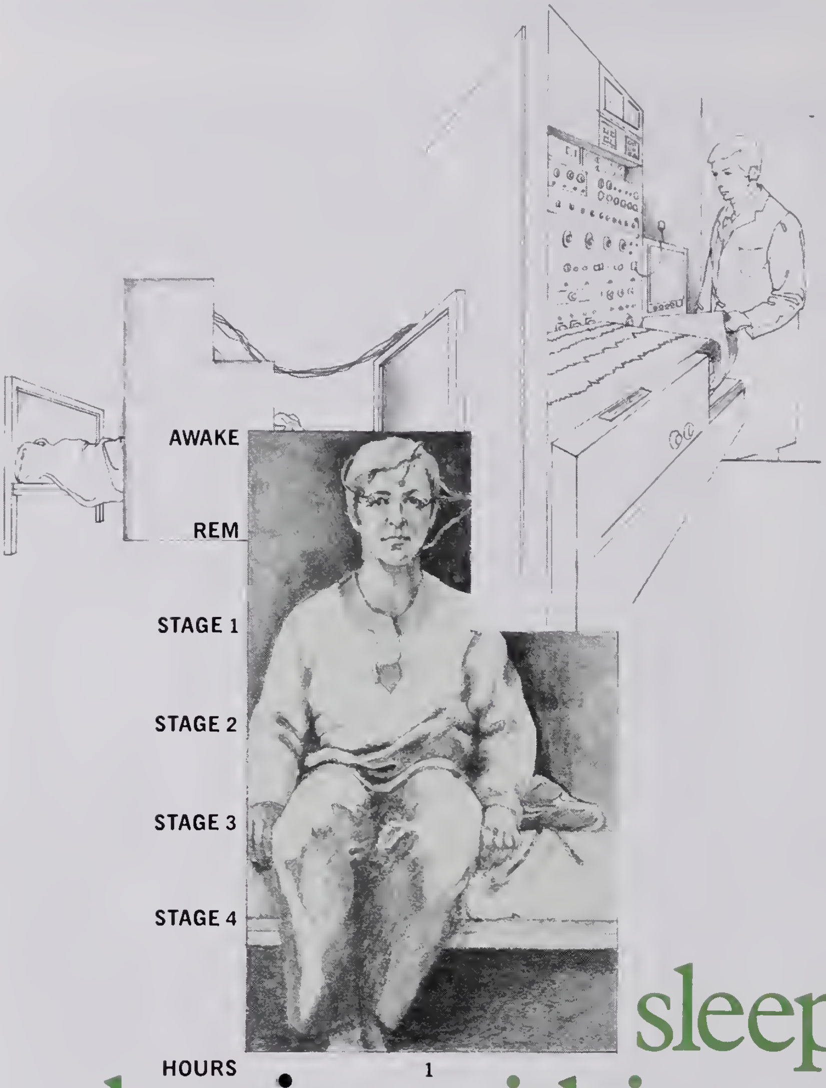

sleep begins within 17 minutes, on average... an initial benefit of

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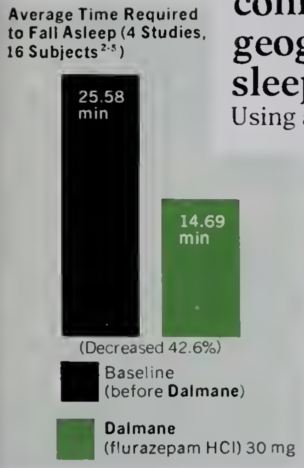
(flurazepam HCl) **proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home**[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

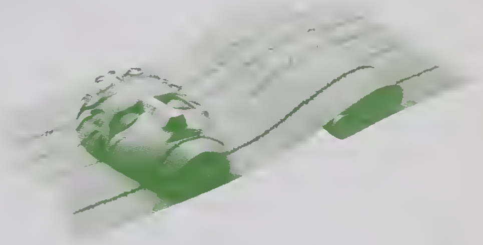
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®

(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

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*E.D. Freis: The Modern Management of Hypertension, V.A. Information Bulletin, 11-35.

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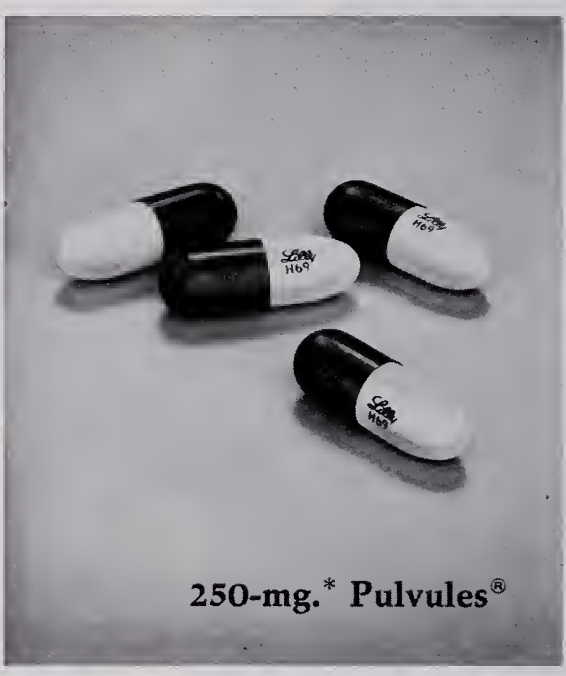

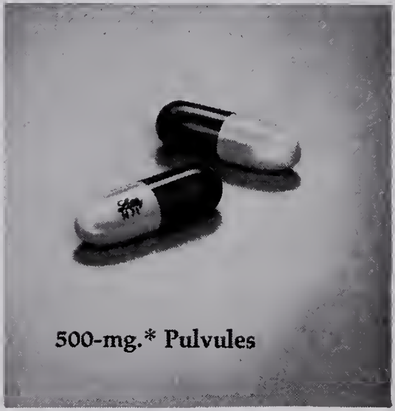

*Equivalent to cephalexin.

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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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BHARATHI BHOOPATHI, M.D., FRANK OSTAPOWICZ, M.D.
and LUIS DEL ROSARIO, M.D., *St. Louis*

Fluothane (Halothane) Anesthesia and Acute Hepatic Toxicity

Case Report

The patient is a 50-year-old black woman, Gravida 4, Para 4, Aborta 2, who was admitted to St. Louis City Hospital for an elective hysterectomy. Her first admission was on Oct. 2, 1972 because of irregular and heavy vaginal bleeding during the preceding year, with heavy flow during the 12 days before admission. Uterine dilatation and curettage was carried out and proliferative endometrium was obtained. Her past history was significant in that she was treated for hypertension two to three years prior to admission. She admitted two pillow orthopnea, occasional paroxysmal nocturnal dyspnea, palpitation and dyspnea on effort and sharp pain "radiating along the sternum" provoked by effort and relieved by rest. She stated she had arthritis of her hips and knees. She denied excessive use of alcohol.

On first admission, the patient underwent a dilation and curettage uneventfully. The blood pressure on admission was 140/95 mm Hg. At the time of discharge it was 120/80 mm Hg.

The patient was readmitted on Oct. 20, 1972. The clinical findings were positive for Grade I hypertensive retinopathy, sinus rhythm present and no murmurs were noted. Peripheral pulses were strong. Neurological examination was unremarkable. The uterus was enlarged to 12 to 14 weeks gestation. The patient underwent total abdominal hysterectomy with bilateral salpingo-oophorectimy on Oct. 24, 1972. Abdominal exploration was negative. At the start of the operation, the blood pressure was 200/140 mm Hg and was about 170/120 mm Hg during the next one hour and 45 minutes.

It was 200/140 mm Hg at the end of the operation and declined to 166/105 mm Hg in the recovery room. Pentothal, anectine, fluothane and nitrous oxide were employed.

After surgery, the patient was febrile, 100F-101.4F, until Nov. 3, 1972. Examination of her abdomen revealed mild tenderness in the lower abdomen. Pelvic examination was considered within normal limits except for minimal cuff induration. There was no purulent vaginal discharge. Homan's sign was always negative; blood pressure was consistently 150/90 mm Hg. During this period 500 mg of ampicillin were given intramuscularly every 6 hours for possible infection.

On Nov. 3, 1972, the abdominal pain became more severe. Demerol was given repeatedly for relief during the next few days. Temperature rose to 103F-104F. There were no new physical findings. A regimen of 0.5 gm of kanamycin administered intramuscularly twice a day was started. Aspirin suppositories and cold blanket were employed in an effort to control temperature.

For three days, her temperature continued to reach 104F-105F. The abdomen was described as soft with marked lower abdominal tenderness. On Nov. 5, 1972, the abdominal incision was opened to drain a suspected abscess. No pus was found. Penicillin (10-, 20- and 10-million units) was given on these days, respectively. An intravenous pyelogram on Nov. 6, 1972 was essentially unchanged from the one on Oct. 6, 1972.

On Nov. 6, 1972, a consultant found the patient febrile, but not toxic, and awake, cooperative and able to respond to questions. She stated that she had pain on both sides of her chest, which was made worse by coughing. She said she was spitting up small clots of blood. There was a maculopapular rash of the face, particularly in the parotid area and behind the ears. The

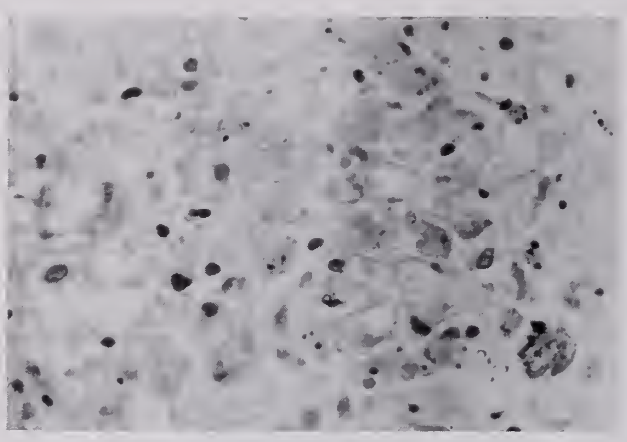

Fig. 1 Massive necrosis and resorption of liver cells with cytoplasmic vacuolization and acidophilic inclusions (H & E stain, × 250).

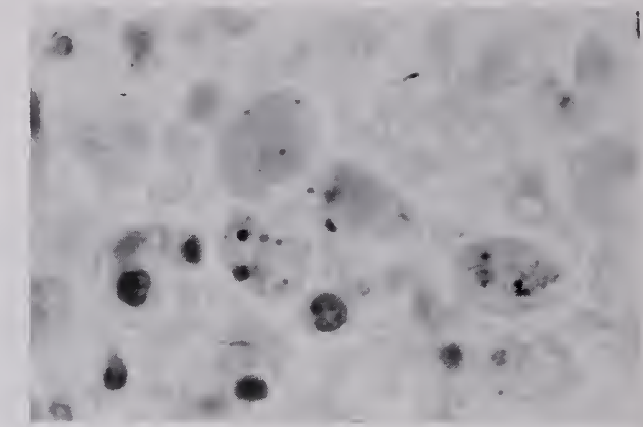

Fig. 2 Necrotic liver cells with acidophilic intracytoplasmic masses and vacuolization (H & E stain, × 1,000).

conjunctiva were clear. There was no lymphadenopathy. There was S_3 gallop and an ejection murmur in the second right intercostal space and infraclavicular area. There were a few rales at the left base. There was exquisite tenderness in both lower quadrants, the left being greater than the right, with rebound pain more severe than on direct pressure. There was no edema. Peripheral pulses were full. Homan's sign was negative.

On Nov. 7, 1972, rales and wheezes were directed over the entire right posterior chest and the lower left posterior chest. She complained of chills. That evening, she was said to have a "noisy cough" which provoked retching and vomiting of blood-tinged fluid and coffee ground material.

During the afternoon of Nov. 8, 1972, her condition again changed. She was drowsy, difficult to arouse, confused, irritable and incoherent. A visitor said she did not recognize him. Her temperature fell progressively during the day to 98F (R), BP—110/60 mm Hg. Pulse rate was 112/min and respiratory rate was 28/min. By midnight, she was stuporous and responsive only to painful stimuli. Two grams of cephalothin sodium (Keflin) every six hours and 60 mg of gentamicin three times daily were initiated. Urinary output decreased to 150 ml in 24 hours.

On Nov. 9, 1972 at 3 AM, blood gases revealed the pH to be 7.533, PO_2—96.3, PCO_2—20.3. She was comatose, with pink, frothy sputum on her lips; jaundice; rash still present; and trismus. Other findings included absent abdominal reflexes, no response to plantar stimulation, biceps and patellar reflexes were 2+.

The peripheral pulses, including dorsalis pedis, were present. Spinal tap was described as traumatic with some clearing during second and third collections.

At 8:30 AM, 50 ml of "dark, amber" urine were obtained by catheters; the specific gravity was 1.017. At 11:15 AM, 500 ml of "dark, amber" urine was obtained on reinsertion of catheter. Temperature at that time dropped to 95F (R); blood pressure was 180/110 mm Hg; respiratory rate was 32/min; and pulse rate was 120/min.

She was taken to the radioisotope laboratory (for a brain scan) where she vomited blood. Shortly thereafter, the drainage from the catheter was noted to be bloody. Dextran, heparin and blood were administered. Efforts at resuscitation following cardiac arrest were unsuccessful and she died at 4:15 PM.

On postmortem examination, there was a small periappendiceal abscess which was localized. There were no thrombi in any great veins to account for evidence of thrombophlebitis. The liver was slightly enlarged (1,400 gm), markedly congested and somewhat friable. On microscopic examination of the liver, there was massive hepatic necrosis with no signs of regeneration. The hepatic parenchymal cells were completely necrotic, particularly in the central lobular areas. There were only a few small foci of relatively intact hepatic parenchymal cells. The necrotic liver cells were generally shrunken, while in other areas, they exhibited swelling, marked acidophilia and vacuolization of the cytoplasm (Figs. 1 & 2). The sinusoids were somewhat dilated and contained small numbers of pigment laden macrophages as well as neutrophilic and mononuclear cells. There was periportal infiltration of monuclear cells and neutrophils. Minimal cholestasis was present.

Reticulum stain showed the usual pattern of the reticulum fibers with no evidence of condensation as yet. Masson Trichrome stain showed no evidence of reactive fibrosis.

LABORATORY DATA

10/2/73 (first admission): Hb—8.5 gm%; Hct—26%; WBC—7,800; 1 BAS—50 Seg; 47 Lym; 2 Monos; SpGr—1.021; pH—5.5; Alb—0; Gluc—0; Micro—Many RBC; 0-1 WBC; Na—150; Cl—113; CO_2—23; K—4.2; BUN—16; Gluc—85.

10/6: IVP—Incomplete duplication left collecting system—otherwise, neg.

10/20: Hb—11.5; Hct—36; WBC—9,100; EO—2; Myel—2; JK—1; ST—8; SEG—72; Lym—14; Mono—1.

10/23: Hb—10.6; Hct—33; EO—1; ST—4; SEG—53; Lym—41.

10/25: Hb—10.8; Hct—33; WBC—12,600; ST—3; SEG—80; Lym—13; Mono—4, many target cells.

11/5: Hb—10.1; Hct—30; PTS—502,000; WBC—

9,500; EO—1; Myel—1; JK—9; ST—14; SEG—61; Lym—10; Mono—4.

11/5: Hb—10.1; Hct—32; PTS—496,000; WBC—10,000; EO—2; ST—20; SEG—53; Lym—25; Mono—5% large lymphoblast type.

11/8: Hb—9.8; Hct—29; PTS—258,000; WBC—12,500; EO—1; Myel—3; JK—2; ST—42; SEG—34; Lym—18; Mono—1 cell target cells.

10/21: Na—145; Cl—109; CO_2—27; K—3.9; BUN—19; Gluc—115.

11/2: Na—137; Cl—101; CO_2—29; K—4.0; BUN—7; Gluc—115.

11/8: Na—137; Cl—97; CO_2—15; K—4.5; BUN—9; Gluc—110.

11/9: Na—139; Cl—100; CO_2—20; K—3.9; BUN—9; Gluc—122.

11/6: ALK—3.1; Ca—9.0; P—3.7; Chol—130; VA—5.3; Cn—1.0; BIL—2.0; AlkP—220; CPK—170; LDH—>1,800; SGOT—>750.

11/8: ALK—1.7; Ca—7.9; P—3.1; Chol—130; VA—6.3; Cn—2.4; BIL—4.6; AlkP—185; CPK—220; LDH—>1,600; SGOT—>750.

10/23: Negative chest.

10/27: Urine culture—no growth; vaginal cuff—no growth.

11/1: Blood culture—no growth.

11/7: Blood culture—no growth.

11/8: Urine culture—no growth.

11/10: CSF culture—no growth.

Clotting Studies—11/9/72: Platelets: 391,000; PT—>90 sec; PT (1:1, patient's: normal)—16.4 sec; PTT—>110 sec; PTT (1:1, patient's: normal)—48.9 sec; TT—27.6; TT (1:1, patient's: normal)—19.4; FDP—100 μg/ml (N = 6 μg/ml or less); Fibrinogen—158 mg% (N = 200-400 mg%).

DISCUSSION

Fatal hepatic necrosis following halothane anesthesia occurs in rare instances and is associated with a recognizable clinical pattern and characteristic but not pathognomonic, morphologic changes. Unexplained postoperative fever was one of the most constant features indicative of liver damage.

Frequency of fatal hepatic necrosis is increased in obese subjects and in patients who are hypercarbic under halothane anesthesia.

In 1956, Raventos[1] studied the concentration of fluothane in the arterial blood of dogs at different depths of anesthesia. A closer study of the accumulation and distribution of halothane in the body and its exhalation was necessary, and later work was followed by Duncan and Raventos[2] in 1959. Duncan *et al*,[2] in studying the distribution of halothane in tissues after various periods of anesthesia, found the highest concentration to be in the fat. After several hours of anesthesia, the levels in fat were up to 20 times the concentration in other organs, a finding that could be anticipated in light of its affinity for lipid. Obesity may be a factor that delays the elimination of halothane or its products. Reports of hepatotoxicity after the use of halothane began to appear in 1958.[3]

The authors describe a case of massive hepatic necrosis following halothane anesthesia. Little concern has been given to postoperative fever as a reaction to anesthetic agents. There are multiple potential causes for postoperative febrile reactions. However, it probably would be an important diagnostic measure to determine serum glutamic-pyruvic transaminase levels in all patients with postoperative fever after use of halothane, since impaired hepatic function may develop in those patients who are hypercarbic under halothane anesthesia. Drs. Bhoopathi and Ostapowicz are from the Department of Gynecology and Obstetrics, St. Louis University School of Medicine and Dr. Del Rosario is from the Department of Pathology, St. Louis City Hospital.

The excretion rate of metabolic products of halothane is slow. A direct toxic effect of halothane on metabolic activity has not been established and it is possible that the enzymatic breakdown could bring about the formation of toxic by-products. As suggested by Cohen,[4] variation in enzymatic activity from one person to another could be an important factor in possible toxicity.

Halothane anesthesia may produce hypotension.[5] The reduced hepatic blood flow, according to Ahlgren,[6] accompanies deep halothane anesthesia even in the absence of hypercarbia and may be more important than hypotension. Hypercarbia potentiates the impaired hepatic blood flow and, as shown by Morris and Feldman,[7] impaired hepatic function may develop in patients who are hypercarbic under halothane anesthesia.

In the national halothane study,[5] autopsies on 10,171 patients revealed massive necrosis of the liver in 82 and intermediate hepatic necrosis in an additional 115 patients. Of 254,898 patients who were administered halothane as on anesthetic agent, 14 recipients had massive or intermediate necrosis with no other discernible cause and the postoperative death rate was 1.87%.

Reports indicate that single exposure to halothane was associated with hepatic necrosis in 1.02 per 10,000 patients, but the incidence of massive hepatic necrosis after multiple exposures to the agent was 7.1 per 10,000 patients as compared to an incidence

(Continued on page 586)

PATRICK C. REDDIN, M.D., ***Mexico***

Changing Management of Breech Presentation

THE FETUS presenting breech is exposed to greater hazards both regarding mortality and morbidity than a peer of similar weight and gestational age presenting vertex. It is the factor of morbidity which is appropriately receiving more and more scrutiny rather than just survival versus nonsurvival. Muller *et al* directed our attention to the poor developmental results in a small group of breech babies followed nine years.[1] A startling 24.5% had to repeat one or more grades in school.

MATERIALS AND METHODS

The years 1968 to 1972, inclusive, saw 281 breech presentations cared for at the University of Missouri-Columbia Medical Center (UMMC). These were reviewed by comparing standard parameters such as birth weight, gestational age and route of delivery with outcome. Where possible, late follow-up of growth and development was included.

RESULTS

In the 281 cases, 52 perinatal losses occurred. Twenty-six were stillborn and 26 were neonatal deaths. Table 1 gives some associations.

It is immediately apparent that prematurity played a sizeable role. Combining stillbirth and neonatal deaths, 38 of 52 occurred in infants less than 33 weeks. This is 73% of the total fetal wastage.

TABLE 1

BREECH, 281 CASES, FETAL LOSS

26 Stillbirths (%)		*26 Neonatal Deaths (%)*	
33 wk	54	33 wk	92
Bleeding	27	Bleeding	27
Cord	15	Cord	7
DM & EF	15	DM & EF	0
PROM	15	PROM	19

Third trimester bleeding, either previa or abruption, was present in more than one quarter of both stillbirths and neonatal deaths.

Other complications seen with sufficient frequency to deserve mention were cord accidents, diabetes, erythroblastosis and premature rupture of the membranes.

It becomes difficult in this hodge-podge of obstetric pathology to assign a primary cause of a bad result. Was it due to the breech presentation and the mechanics of delivery? Or, was it due to intrauterine hypoxia secondary to third trimester bleeding or any of the other problems in the list? Where fetal mortality is noted to be "corrected," it is only when the fetal loss was clearly secondary to some disorder such as abruption, erythroblastosis or diabetes. Where any doubt was felt, the breech presentation was assigned as the cause of the problem.

Perhaps the best place to start is with survival, since it is such a visible end point. Table 2 extrapolates data from the University of Colorado[2] and compares expected mortality at a given gestational age with actual mortality in our group of breech deliveries. The first column refers to gestational age in weeks. The second column shows mean mortality in percent when the infant is appropriate size for gestational age. The third column shows actual mortality in our breech babies. One notes that at 34 to 35 weeks, mortality is increased two and one half times in breech; at 36 to 37 weeks, increased four times; and at 38 to 42 weeks, increased three times.

TABLE 2

BREECH, 281 CASES, NEONATAL DEATH

	Colorado Mean (AGA) (%)	*Breech Series (%)*
30-33	35-15	29
34-35	6	15
36-37	.6	2.3
38-42	.2	.6
>42	.6	0

Table 3 divides perinatal loss into that occurring prior to 36 weeks and that occurring later than 36 weeks. This information could be subdivided into smaller blocks, but the outcome is the same. Even where prematurity is reduced, fetal mortality in

TABLE 3

BREECH, 281 CASES—BY GESTATIONAL AGE

	<36 wk	*>36 wk*
Number	62	219
Fetal loss	60%	6.8%
Corrected	—	3.2%

breech is still high and, one concludes, due in great part to the presentation.

Table 4 relates weight to mortality. Though weight is far less important than gestational age in newborn performance, it is included for completeness.

TABLE 4

BREECH, 281 CASES—BY WEIGHT

	<1,000 gm	*1,000-2,499 gm*	*>2,500 gm*
Number	21	71	189
Fetal loss	100%	34%	4.7%
Corrected	100%	14%	2.1%

In order to minimize the influence of prematurity while comparing route of delivery and survival, Table 5 was constructed. Two hundred and nineteen babies were delivered at or beyond 36 weeks gestation. The absence of fetal mortality when the delivery was accomplished by cesarean section is worthy of note. Full breech extraction was generally limited to situations of fetal distress or second twin. Partial breech assist was the method of choice, usually with Piper forceps to the aftercoming head. In a patient well chosen for vaginal delivery, this is still the route to be preferred and should be easy mechanically.

TABLE 5

BREECH, 219 CASES, >36 WK.

	Cases	*Corr Mortality (%)*
Partial breech assist	103	3
Full breech extraction	29	17
C-Section	87	0

Table 6 indicates that our current rate of cesarean section in breech presentation is 31%. We feel that the results justify the high incidence.

TABLE 6

BREECH, 219 CASES >36 WEEKS, INDICATIONS FOR SECTION

	87 Cesarean Sections	
Breech	68	31% rate
*Other	19	

*Repeat, previa, cord, diabetes.

Two hundred and eighty-one breech presentations were reviewed at the University of Missouri-Columbia Medical Center. Comparisons were made of birth weight, gestational age and route of delivery with fetal outcome. Results revealed that fetal morbidity and mortality is higher in breech than in vertex presentation. When vaginal delivery is not considered feasible, aggressive use of cesarean section is suggested. The author is in the private practice of obstetrics and gynecology.

Morbidity, as previously indicated, is more difficult to ascertain (Table 7). Only about one third of the infants discharged alive have been followed here more than six months. Of that number, five have central nervous system (CNS) damage and two of these have major damage. Labor and delivery is implicated in all five. The one infant delivered by section who has CNS damage was showing severe fetal distress during labor prior to the abdominal delivery.

DISCUSSION

Our management of breech presentation begins in the outpatient clinic. Where breech presentation with intact membranes is identified in the antenatal clinic prior to labor, external version is attempted. If breech persists, management is based upon determination of the size of the fetus, the type of breech, the size of the pelvis and (where labor is permitted) the quality of the uterine contractions.

Fetal size is notoriously difficult to determine by any method. We depend on multiple independent examiners and, recently, the use of ultra sound scan to measure biparietal diameter. Babies can usually be classified with good agreement into three groups—small, average and large. We are reluctant to deliver vaginally infants thought to be 8½ lbs. or more.

Also considered are the factors of station and type of breech. To generalize in an attempt to rigidly quantitate the influence of these parameters can never be completely accurate. Individual case evaluation is required. One can say, however, that a footling or complete breech high in the pelvis is a much worse prognostic finding than a frank breech seated deep in the true pelvis. The hazards

TABLE 7

BREECH, 281 CASES

Morbidity information grossly lacking
- 229 live babies discharged
  - 81 followed 6 months or more
    - 5 of the 81 CNS damage
      - 3 minor, 2 major
      - 4 vaginal deliveries
      - 1 section (in labor severe fetal distress)

of cord accident in the first instances are formidable.

The pelvic capacity is evaluated clinically and by x-ray when 36 weeks has been reached. Mengerts indices (Ap inlet × Tv inlet = $\frac{x}{145}$ = %; AP midplane × Tv midplane = $\frac{x}{125}$ = %) as well as individual measurements are considered. The rough scheme followed is this: for safe vaginal delivery, a small baby requires an average pelvis; an average baby requires a large pelvis; a large baby requires an immense pelvis.

When vaginal delivery is considered feasible, we then insist on normal progress in labor and do not augment with pitocin, turning rather to abdominal delivery where obstructed labor is clinically manifest.

SUMMARY

1. Breech mortality and morbidity to the fetus is higher than vertex presentation.
2. Conversion to the vertex in the outpatient clinic is desirable.
3. Management of the persistent breech is determined by fetal size, pelvic size, type of breech and effectiveness of labor.
4. Aggressive use of section is rewarding, but to say all breech presentations should be delivered abdominally is not warranted.

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Fluothane (Halothane) Anesthesia

(Continued from page 583)

of only 2.1 per 10,000 after multiple exposures to other general anesthetic agents.

Unexplained liver failure was usually characterized by fever within two or three days after operation, soon followed by jaundice (which deepened progressively) and by a tender palpable liver. Confusion, somnolence and a flapping tremor may develop within a week after the onset of fever. The confusion usually progresses rapidly to coma and death. Hypotension would be a later manifestation usually appearing only on the day of death. The total duration of illness would be brief, the longest interval between the onset of symptoms of liver failure and death being nine days. The course was similar to that associated with delayed chloroform poisoning. Jaundice may be a less frequent manifestation, usually only terminally. In most cases, hepatic injury was not suspected during life.[8]

The appearance of the liver on histological examination in the present case of massive hepatic necrosis was in most instances consistent with that observed in shock or hypoxia, reflecting the severe circulatory disorders. The sections were characterized by centrilobular congestion and ultimately pooling of sinusoidal blood. Paralleling this was alternation and disappearance of parenchymal cells with relatively little inflammatory reaction.

In order to define more clearly the issue of whether or not halothane may produce massive necrosis of the liver as contrasted to other general anesthetic agents, the presence of symptoms and laboratory findings consistent with massive necrosis and resultant hepatic coma seems to be of critical importance.

Past reports have emphasized at least one previous exposure to halothane prior to the development of hepatic toxicity. Our report is believed to be one of the first to reveal that a primary exposure can result in the same pathologic entity in a highly susceptible patient.

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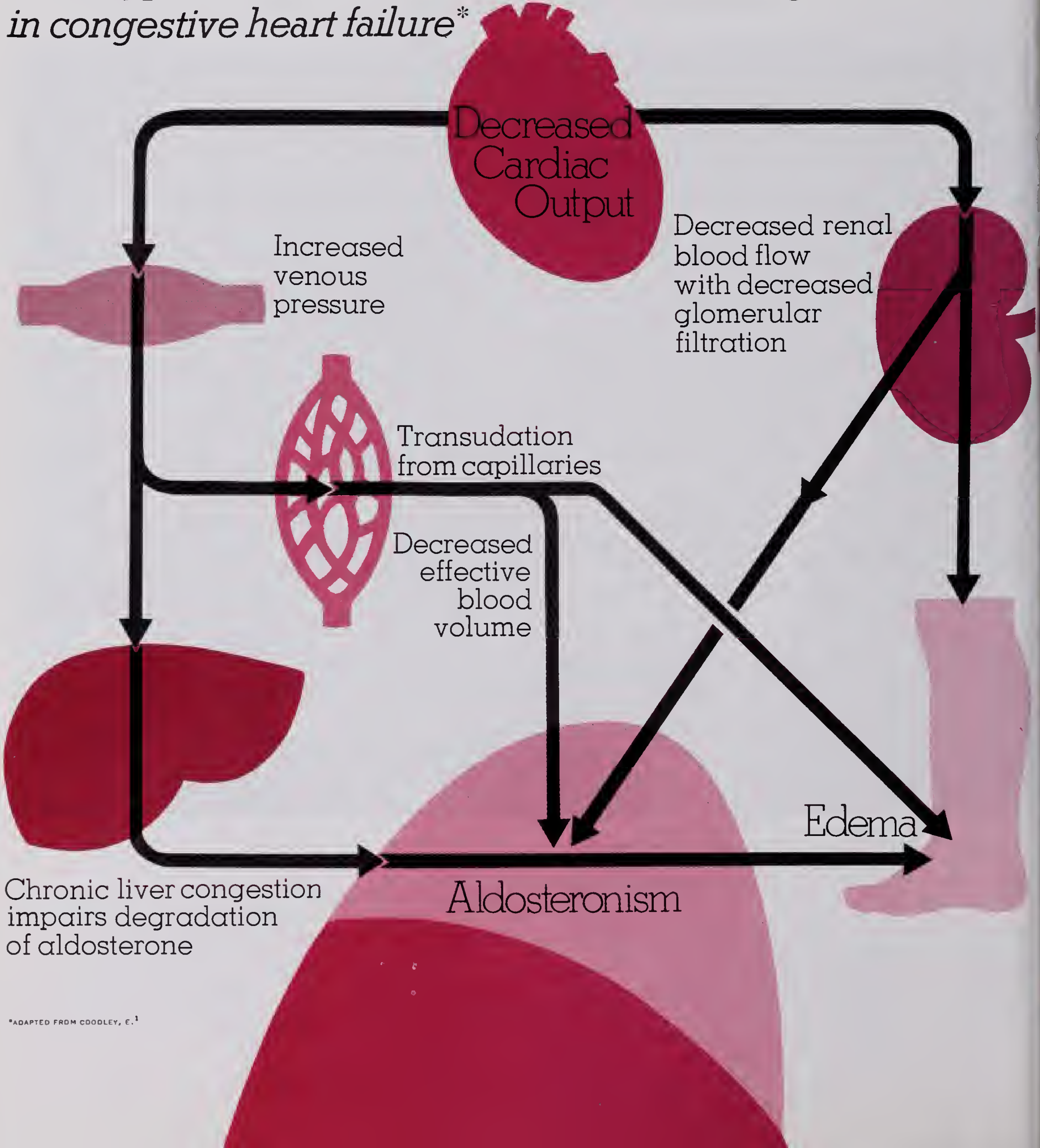
In congestive heart failure...
secondary aldosteronism

*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**


Decreased Cardiac Output
Increased venous pressure
Decreased renal blood flow with decreased glomerular filtration
Transudation from capillaries
Decreased effective blood volume
Edema
Chronic liver congestion impairs degradation of aldosterone
Aldosteronism

*ADAPTED FROM COODLEY, E.[1]

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- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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Opinion & Dialogue

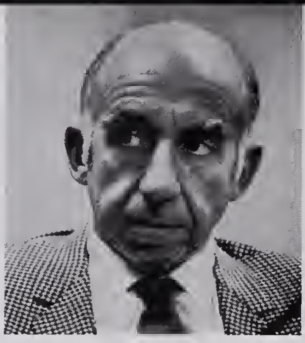
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

He a Source of Information?

Yes, with certain reservations.
e average sales representative
s a great fund of information
out the drug products he is re-
onsible for. He is usually able to
swer most questions fully and
elligently. He can also supply
prints of articles that contain a
eat deal of information. Here,
, I exercise some caution. I usu-
y accept most of the statements
d opinions that I find in the
pers and studies which come
m the larger teaching facilities.
oes without saying that a physi-
n should also rely on other
urces for his information on
armacology.

ining of Sales Representatives

Ideally, a candidate for the
sition as a sales representative
a pharmaceutical company
uld be a graduate pharmacist
o has a questioning mind. I don't
nk this is possible in every case,
so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

acity they are indeed useful;
ticularly in the fact that they
seminate broadly based educa-
nal material and serve not just
"pushers" of their drugs.

Other Side of the Coin

Obviously, the pharmaceuti-
companies are not producing all
material as a labor of love—
y are in the business of selling
ducts for profit. In this regard
ambitious and improperly moti-
ed sales representative can
t a negative influence on the
cticing physician, both by pre-
ting a one-sided picture of his
duct, and by encouraging the
ctitioner to depend too heavily
rugs for his total therapy. In
e ways, the salesman has often
orted objective reality and
ermined his potential role as an
cator.

Industry Responsibility

Since the detail man must be
nformation resource as well as
presentative of his particular
rmaceutical company, he
uld be carefully selected and
thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

*Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005*

P·M·A

JAMES F. McCOOL, M.D., ***St. Louis***

Infectious Mononucleosis Complicated by the Guillain-Barré Syndrome

Case Report

INFECTIOUS MONONUCLEOSIS is a common disease and usually benign in its ultimate outcome. The Guillain-Barré syndrome is an uncommon complication of infectious mononucleosis, but its outcome may be fatal. The following report illustrates a case of infectious mononucleosis complicated by Guillain-Barré syndrome. A review of the literature and discussion is included.

CASE REPORT

A 36-year-old white man was seen for the first time on April 28, 1965. He complained of a headache of five-days' duration, soreness in his legs and a "swelling" on the left side of his neck. Prominent adenopathy was noted in the left posterior cervical area. A white blood cell count was 13,050 with 84% lymphocytes and 90% of the lymphocytes appearing atypical. The patient was initially treated symptomatically at home with rest and acetylsalicylic acid. He developed increasing weakness and was unable to have a bowel movement despite medication. On May 1, 1965, he was hospitalized. Physical examination on admission revealed an alert white man in some distress and complaining of pain in his shoulder girdle and in his legs. He also noted a tingling sensation in his hands and numbness of his feet.

Physical examination revealed the following vital signs: temperature 98 F; blood pressure, 120/80; pulse rate, 88/minute and regular; and respirations, 20 per minute. Examination of the neck revealed tender and enlarged nodes in the left posterior cervical area; the carotid pulsations were strong with no bruit present and the thyroid was not palpable. The skin was normal. No abnormalities were found when examining ears, eyes, nose and throat. Examination of the chest, heart and lungs were within normal limits. There was some tenderness to direct pressure over the lower back; examination of the abdomen was normal with no splenomegaly. There appeared to be some flattening of the facies bilaterally but, otherwise, the cranial nerves were intact, including facial sensation, hearing and vibratory sensation. Examination of the extremities revealed some proximal weakness in both upper extremities, and the patient was unable to abduct his arms above the shoulder level. Proximal limb weakness of a moderate degree was present in both lower extremities, and the patient was unable to rise from a squatting position without assistance. The deep tendon reflexes were absent with the exception of a minimal left biceps reflex. No pathological reflexes were elicited. Sensation was intact, including vibratory and position sense. There was increased muscle tenderness and tendon pain. Examination of the genitalia and rectum were negative.

A lumbar puncture was performed. Opening pressure was 110 mm H_2O; clear fluid was obtained. Studies of the spinal fluid showed 13 WBC/cu mm (100% lymphocytes); protein, 280 mg/ml; and glucose, 68 mg/100 ml. Pandy Test was positive; Venereal Disease Research Laboratory (VDRL) was nonreactive; and collodial gold curve was 0000110000. No organisms were seen on initial smear of spinal fluid and no growth was present in 72 hours. Serum heterophile antibody studies were as follows: heterophile, 1:1,792; guinea pig adsorption, 1:448; and beef adsorption, 1:7. Complete blood counts on admission were hemoglobin, 14.8 gm/100 ml; hematocrit, 42%; white blood cells, 7,440/cu mm with 69% lymphocytes (many atypical). Other studies included fasting blood glucose, 65 mg/100 ml; blood urea nitrogen, 10 mg/100 ml; serum glutamic pyruvic transaminase, 395 units/ml; urinalysis, pH-5; specific gravity, 1.019; acetone, small amount; albumin and glucose, negative; and microscopic examination, negative. Serum bilirubin value was 0.2 mg/100 ml, one minute, and 0.3 mg/100 ml, total. Other values were serum proteins, 7.1 gm/100 ml; albumin, 4.2 gm/100 ml; and globulins, 2.9 gm/100 ml. The chest x-ray was normal and the electrocardiogram revealed a sinus rhythm and was within normal limits.

Initially, the patient was given Darvon Compound for pain and bed rest was prescribed. The pain in his extremities persisted and the weakness became progressively worse. Two days after admission, he was unable to walk to the bathroom. The patient now required parenteral Demerol for his pain; his arm weakness prevented him from feeding himself. A liquid diet was started because he had difficulty in swallowing solid food. Because of apparent worsening of symptoms, the patient was moved to the intensive care unit on the third hospital day. Preparations were made for artificial respiration if needed. A regimen of prednisone was started with 60 mg on the first day and then a daily maintenance dose of 40 mg. The patient noted some improvement in the next 24 hours with an increase in appetite and less weakness, but the pain persisted. After three days, he was removed from the intensive care unit. Improvement from this point was slow but steady; corticosteroids were gradually reduced and discontinued prior to his discharge from the hospital. Within one month after his discharge, the patient was able to return to work. Two years later on August 10, 1967, the patient had a physical examination and results were completely normal. He was working long hours without difficulty, and his only complaint was an occasional numbness in his fingers and toes since his illness.

Discussion

The history of infectious mononucleosis (IM) begins with a description of glandular fever by Pfeiffer in 1889. Neurological complications with this disease were first reported in 1931.[1, 2] In 1932, Paul and Bunnell described the presence of heterophile antibodies in the serum of a patient with IM. The first case report of the Guillain-Barré (GB) syndrome complicating IM was published in 1942.[3] A comprehensive report in 1950[4] found seven cases in the literature of GB complicating IM and added one case. The total of reported cases by 1954 was said to be 13.[5] By 1965, it was 35.[6] Several cases have been added in the last few years,[7, 8] including two in a recent report.[9] It appears, therefore, that approximately 40 cases of GB complicating IM have been reported in the literature in 30 years since the initial case report. These cases are numerically small compared to the frequency of IM and illustrate the rarity of this complication.

The importance of GB as a complication of IM is out of proportion to its frequency. This was well illustrated by a review[10] which listed 59 cases of neurological complications of which seven were GB and four of these were fatal. This complication is responsible for a fatal outcome in an otherwise usually benign disease.

The GB syndrome has had many synonyms in the past and was comprehensively discussed in 1949.[11] It is characterized by a polyradiculoneuropathy, which may be predominantly motor or sensory. Changes in the amount of protein or number of cells in the spinal fluid are regarded as incidental to this disorder (although cell-protein dissociation was originally considered essential). Respiratory failure is the final event in the great majority of fatal cases.

IM is well documented in the present case. Adenopathy preceded the neurological symptoms and a lymphocytosis with predominance of atypical lymphocytes was noted. Finally, a distinctly elevated heterophile titer and confirmatory adsorption tests were demonstrated. It has been noted that some previously reported cases of GB which were considered as a complication of IM were not always based on all current diagnostic criteria.[6]

Heterophile antibodies have been demonstrated at times in the spinal fluid.[12] This was not attempted in the present case. In one reported case,[13] atypical lymphocytes were found in the spinal fluid in a patient with a meningitis-like picture. This led to heterophile tests which were positive in both the blood and spinal fluid. No atypical lymphocytes were found in the blood. The lymphocytes found in the spinal fluid in the present case were not described as atypical, but no special attempt was made to identify atypical cells. Perhaps, a more diligent search for such cells would yield more positive findings.

Although infectious mononucleosis complicated by the Guillain-Barré syndrome is uncommon, it is important to recognize the syndrome because it is one of the few causes of fatalities in this otherwise benign disease. The author discusses the disease, the danger of respiratory paralysis and effective treatment. Dr. McCool is in the private practice of internal medicine and Senior Instructor in Clinical Medicine, St. Louis University School of Medicine.

Not all neurological complications follow the clinical onset of IM as in the present case. In one series of cases[14] with eight neurological complications (including one GB), a lack of correlation was noted between the onset of IM and the appearance of neurological symptoms. It is apparent that neurological symptoms may precede the clinical signs of IM by as much as two weeks or may occur as long as two weeks after the signs of the disease. In one recent report,[9] a review of the literature yielded eight cases (all with diagnostic heterophile titers) in which neurological involvement was the only major manifestation of IM. It also is of interest that in this same report, the incidence of major neurological involvement in 144 patients with IM was 5.5%; this contrasts with earlier estimates of from 0.37%[10] to 1%.[4] The difference may be at least partially accounted for by a higher index of suspicion of IM as the cause of a puzzling neurological disease.

The etiology of IM is still to be proven. The varying time relationship between the signs of IM and the occurrence of GB (as mentioned above) has been suggested as evidence in favor of direct viral invasion of the nervous system.[4, 14] More recent evidence demonstrating Ebstein-Barr (EB) virus antibodies in the serum of patients with IM suggests that this herpes-like virus may be the cause.[15–17]

Pathological changes have been reported in patients dying of GB complicating IM.[18] There is engorgement of the vessels in the leptomeninges and occasional petechial hemorrhages. Some small perivascular hemorrhages were noted in the cerebrum, and the vessels here and in the spinal cord also were engorged. Ganglion cells in the cerebrum and at all levels of the spinal cord showed some changes (usually mild). Mononuclear cell infiltration of the leptomeninges, anterior nerve roots and peripheral nerves was described. In the peripheral nerves, the myelin sheaths were swollen and the axis cylinders were distorted. The changes described indicated the extensive neurological involvement in the two patients, both of whom died in a respiratory death. These neurological changes may be reversible if acute respiratory failure can be successfully treated. The patient in the present report was fortunate in having an improvement in the course of his disease before acute respiratory failure developed.

The treatment of IM and its complications is largely symptomatic. If GB develops, every effort should be made to give immediate therapy at the first sign of respiratory distress.[6] The use of corticosteroids in this disease in moderate dose levels and for a short term has been reported to decrease the febrile period and to accelerate the return to active duty in some military personnel.[19] On the other hand, a minimal use of corticosteroids is recommended by others[20] since complete regression of the disease, including the blood picture, is unchanged by the use of corticosteroid therapy. However, its use as a trial in serious cases is still supported. In the present case, corticosteroids were not used until the symptoms of a serious complication, i.e., severe and progressive muscle weakness worsened. Onset of improvement did begin shortly after the initiation of steroid therapy, but whether or not this is the result of the steroids or a spontaneous improvement (as reported in some cases not treated with steroids) must remain unanswered. It does seem reasonable to use corticosteroids in the infrequent cases in which the progression to acute respiratory paralysis is possible.

A case of infectious mononucleosis complicated by the Guillain-Barré syndrome has been described. A review of previous reports indicates this to be an uncommon complication of a common disease. A discussion of the disease, including the danger of respiratory paralysis, is included. It is important to recognize the Guillain-Barré syndrome when it complicates infectious mononucleosis, because it is one of the few causes of fatalities in this otherwise benign disease. Hopefully, prompt recognition of this complication and effective treatment of acute respiratory failure, should it occur, would permit spontaneous remission of symptoms and complete recovery in most cases.

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DONALD J. MEHAN, M.D., ***St. Louis***

Ligation of the Internal Spermatic Vein as a Treatment for Infertility

A Review

This summary of a three-year study of 29 patients with left varicoceles treated by internal spermatic vein ligation reveals that nine became pregnant. The author believes that the 32% success rate of this operation justifies this procedure and further study and evaluation of the causative factors in varicoceles responsible for infertility and improvement in technique. Dr. Mehan is in the private practice of urology.

OUR EXPERIENCES over the past three years in the treatment of infertility by primary ligation of the left internal spermatic vein are summarized in this paper. The patients are private patients who were seen in consultation for infertility.

The criteria for selection of patients for ligation of the internal spermatic vein were as follows:

1. A demonstrated history of infertility for more than six months, during which time the couple was trying consciously to bring about pregnancy.
2. The presence of a demonstrable varicocele.
3. Findings on seminogram of at least 40% dead sperm or more.
4. Total sperm count was not considered to be a significant factor in selection.

All patients were carefully questioned for any other possible cause of infertility. In this particular series of 29 patients, none could be found either by history, physical examination or other routine laboratory investigations. Seminograms were performed routinely with standard dilution techniques. In addition, a Blom eosin-nigrosin vital stain was performed, enabling the accurate assessment of the percentage of live-dead forms and the appearance of abnormal forms. Motility was estimated. All patients were admitted to St. Mary's Hospital where the left internal spermatic vein was isolated and ligated at the region of the internal ring, as has been described previously. Simultaneous testicular biopsy was performed. Additional inpatient evaluation included serum cortisol, androgens and determination of FSH and LH levels. In no cases were these found to be abnormal. Additionally, 16 patients had comparative levels of serum cortisol taken from the internal spermatic vein (at least six inches superior to the internal ring) and from the left cubital fossa during the surgical procedure. These were compared to see if there were a significant increase in either one level or the other and to see if there were any relationship to an elevated internal spermatic vein cortisol as a possible etiological agent.

RESULTS

Twenty-nine patients were so evaluated and treated. Of this total, nine became pregnant, resulting in the delivery of normal infants in all cases. Two categories of patients were established on the basis of initial sperm count: the azoospermic and the oligospermic (with counts less than 20 million) and the normo-spermic, those greater than 20 million. All cases will be considered collectively in relation to sperm viability.

Azoospermic: *Eight cases*—Fifty percent of the azoospermic cases showed improvement following ligation of the internal spermatic vein. However, none of these four postoperatively reached normal counts, although one of these couples became pregnant. The patient who achieved pregnancy in the azoospermic group had a postoperative count of 19 million sperm with 50% live forms (Fig. 1, Table 1).

Oligospermic: *Seven cases*—Five of the seven cases showed significant improvement in their postoperative count. One case demonstrated an insignificant decrease in the sperm count and one was lost to follow-up. Improvement in sperm count in these ranged from 25 million to 89 million (average 54.2 million). One case decreased from 17 to 0. In five of the six, oligospermic patients followed the

TABLE 1

15 CASES ASPERMIC AND OLIGOSPERMIC

	CASE	1+	2+	3+	4+	5	6	7	8+	9	10	11	12	13	14	15
COUNT mill/cc	PRE	13	19	7	20	3	20	17	0	0	0	0	0	0	0	0
	POST	54	92	96	63	28		0	19	18	16	6	0	0	0	0
Viability %	PRE	20	20	0	42	0	0	0	0	0	0	0	0	0	0	0
	POST	70	74	70	52	22		0	50	40	60	35	0	0	0	0

= PREGNANCY

Pre- and postoperative results in 15 aspermic and oligospermic patients. Cases #1, #2, #3, #4, and #8 resulted in pregnancy.

viability increase average 41% (10 to 70%).

One case was unchanged and one lost to follow-up. Four pregnancies resulted and these correlated well with increase in counts and motility (Fig. 1, Table 1).

Normo-spermic: In our series, there were 15 normo-spermic patients. In this group, five of the nine patients showed improvement in their counts and viability and conceived. In three cases, sperm counts decreased and two were lost to follow-up. The increase in count varied from 10 million to 85 million. Viability increased in eight patients from 10% to 64%, the average being 36%.

In general, pregnancies in this group correlated well with the observed improvement in the counts.

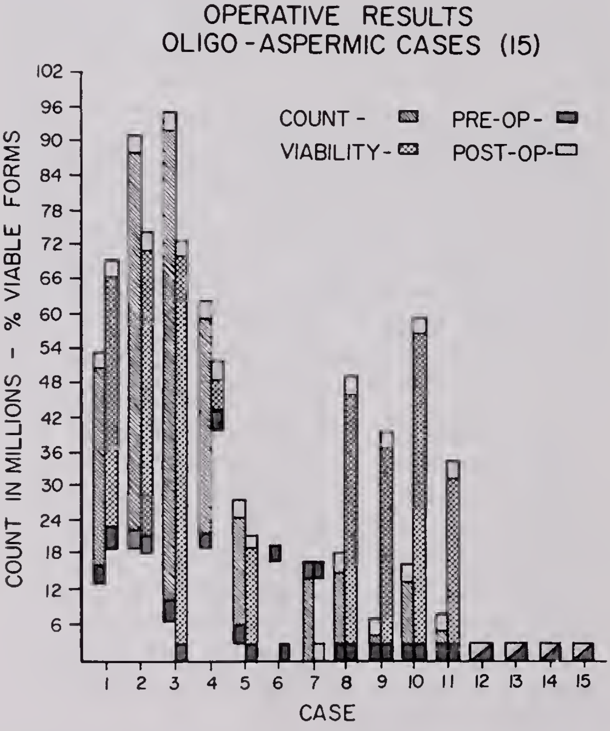

Fig. 1 Comparison of pre- and postoperative counts and viability in 15 oligospermic and aspermic patients.

TABLE 2

14 CASES NORMO SPERMIC

	CASE	1+	2+	3+	4+	5+	6	7	8	9	10	11	12	13	14
COUNT mill/cc	PRE	25	33	50	57	49	23	63	96	48	48	41	91	49	68
	POST	84	59	67	80	96	108	100	106	105		29	57	18	
VIABILITY %	PRE	46	36	20	28	62	38	22	62	18		18	46	18	
	POST	26	75	60	64	72	72	86	74	54		8	42	0	

+ = PREGNANCY

Pre- and postoperative normo-spermic patients. Cases #1 through five resulted in pregnancy.

Of the four cases which showed significant improvement without pregnancies, paradoxically one wife went on the pill, two were divorced and the fourth has not had children (Fig. 2, Table 2).

Testicular biopsies were reviewed in 28 of these cases. No constant lesion was noted nor could we predict the results accurately. Fig. 3 shows a biopsy representing severe maturation arrest. The count improved and pregnancy resulted. Fig. 4 shows marked sloughing and arrest; again pregnancy resulted. In only two of the 28 patients, both azoospermic, could pregnancy be precluded on the basis of testicular biopsy.

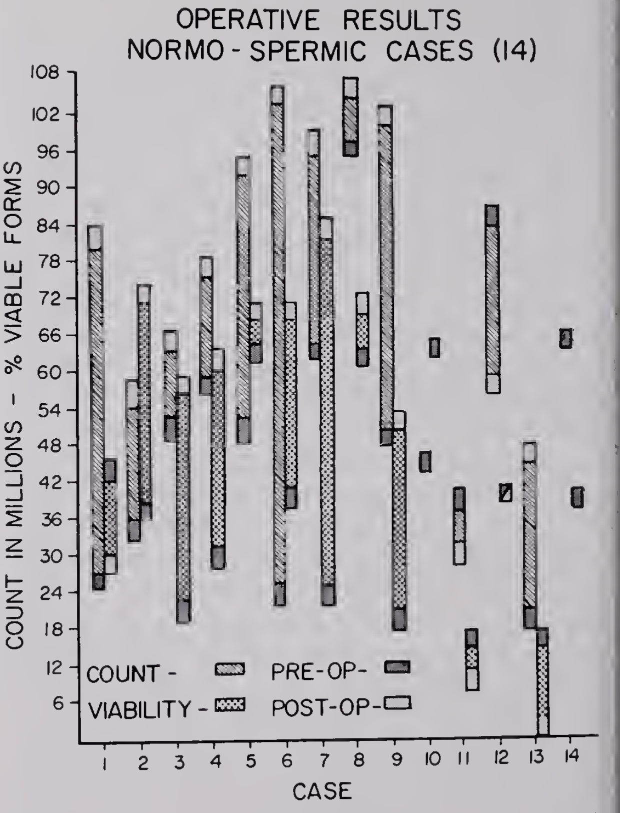

Fig. 2 Comparison of pre- and postoperative counts and viability in 14 normo-spermic cases.

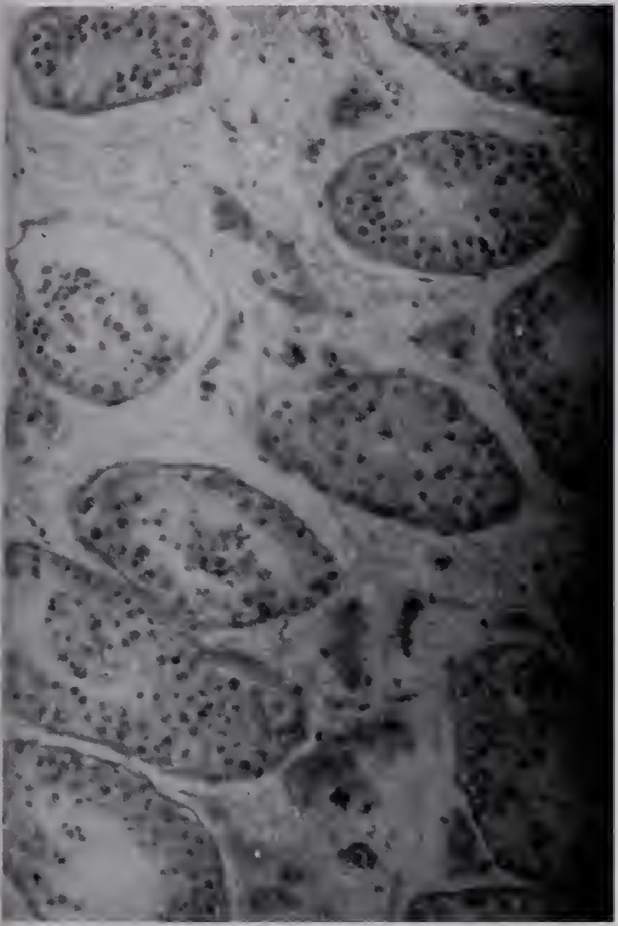

Fig. 3 Testicular biopsy from Case #5 in the normo-spermic group (Fig. 2). Significant degree of maturation arrest is apparent on this specimen. Pregnancy resulted. (Zenker's fixed, ×400.)

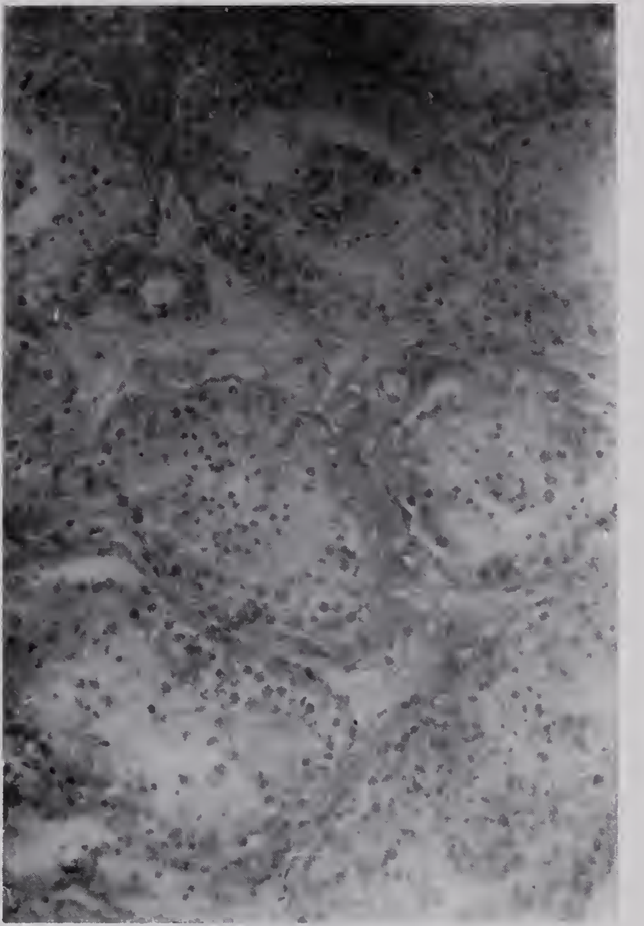

Fig. 4 Biopsy from normo-spermic (Case #2) showing again maturation arrest and premature sloughing with minimal peritubular fibrosis (Fig. 2). Pregnancy resulted. (Zenker's fixed, ×400.)

Discussion

It has been demonstrated by a number of authors that ligation of the internal spermatic vein often has a beneficial effect on the seminogram with a resultant pregnancy. The value of the incidence of pregnancy following this procedure varies from our series from approximately 32% to some reported in the range of 40%. Well over 50% of the patients are improved. The etiologic factors which bring about the changes in the seminogram following ligation of the internal spermatic vein are not clear. We attempted to see if there were some correlation between the steroid levels in the sperrmatic vein, creating a higher steroid level in the testicle with the resultant difficulty. Thus far in our study, we are unable to make any definite statement in this regard, although it is planned to continue this study. On the basis of this and other studies, it would seem to us that the significant factor in measuring the effect of this operation is not in the total sperm count but, rather, in the improvement in the viability and the morphologic characteristics of the sperm. The pregnancy rate in this series, although somewhat disappointing, is still far above what could be expected from other routine types of treatment of these infertile conditions.

Conclusion

Nine of 29 patients with left varicoceles treated by internal spermatic vein ligation became pregnant. The data on these patients are presented. The success rate of this operation is 32%. In view of the difficulties encountered in treating infertility, we feel that this success rate justifies continuing this procedure and further study and evaluation of the causative factors in varicoceles responsible for infertility and improvement in technique.

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President

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The Missouri State Medical Foundation is classified by the Internal Revenue Service under Section 509(a)(3). Individuals may deduct up to 50% of their adjusted gross income for contributions made to the MSMF.

President's Message

Last month, we talked about the cost of medical care and indicated that HMOs, PSROs, etc. are really cost-containment ploys. Should you doubt this, I am going to quote from a letter received by one of our members sent by General American Insurance Co. for Medicare dated August 20, 1974:

James C. Cope, M.D.

> "Dear Doctor .... :
>
> "We have just completed review of your 1972 claims and find it necessary to declare overpayments for unnecessary hospitalization.
>
> "We determined overpayments of nine of the 78 sample claims reviewed and project the overpayment as $5,050 for the year."

I have talked with this physician. There was no hearing. He did not know his cases were being reviewed and he was given no opportunity to defend his judgment.

It occurs to me that this may be a result of the AMA's stand on Pre-admission Certification. Apparently, HEW is saying, "Either certify the admissions before they enter the hospital or we will disallow those we see fit to disallow and assess a fine accordingly."

This physician accepted assignment on his Medicare cases and only because he accepted assignment was it possible for HEW through General American to demand repayment.

There are several morals:

1. Don't accept assignment on Medicare Cases.
2. Be sure your records show that hospitalization was necessary.
3. Refuse to participate in any third-party program where taking assignment is mandatory.
4. Stand together through the County, State and American Medical Association.

"THAT YOU ALLOW TO BE DONE TO YOUR BROTHERS SO SHALL IT BE DONE UNTO YOU."

Must vasodilators and therapy for other diseases come into conflict?

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Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Woman's Auxiliary

50th Anniversary

O suns and skies and clouds of June
And flowers of June together,
Ye cannot rival for one hour
October's bright blue weather.
—Helen Hunt Jackson

"October's bright blue weather" always heralds a month of travel for many members of the Woman's Auxiliary. The National Fall Conference in Chicago is sponsored by the AMA Auxiliary and provides a leadership session for all state presidents and presidents-elect.

Mrs. George J. Lytton
President

The North Central Regional Workshop, also to be held in Chicago, will provide inspiration for many committee members. The MSMA Auxiliary will be represented by Mrs. W. Jack Stelmach, Kansas City, AMA-ERF; Mrs. George P. Wilson, Columbia, Communications; Mrs. Donald A. Fakhoury, Kansas City, Community Health; Mrs. Larry Ozenberger, Plattsburg, Family Health; Mrs. E. E. King, Normandy, Health Education; Mrs. Gerald L. Miller, Kansas City, Legislation; and Mrs. Sam Gaston, Joplin, Membership. Mrs. William R. McPhee, Kansas City, and I will attend as President-Elect and President, respectively.

The annual Missouri Fall Conference is a highlight of the year and will be held in Springfield on October 23-24. Members of the Greene County Auxiliary will be hostesses with Mrs. Carle H. Schroff and Mrs. Don E. Menchetti serving as Conference Chairmen. Mrs. DeArmond Moore is President of the Greene County Auxiliary.

The Fall Conference program includes a workshop for all county auxiliary officers, a panel discussion of "Quality of Life—The Later Years" and a special presentation by the Environmental Protective Agency.

Each of these meetings creates enthusiasm and provides inspiration and information for the work of the coming year.

"There is something in October that sets the gypsy blood astir," wrote Bliss Carman.

Our "Auxiliary gypsy blood" will be set astir again this October by the challenge of workshops and inspirational meetings. These are typical examples of the MSMA Woman's Auxiliary at work.

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

The annual election meeting of the Buchanan County Medical Society was held on September 4 after a dinner meeting in the Empire Room of Hotel Robidoux in St. Joseph.

Dr. G. Tyson Carpenter was named President-Elect; Dr. Richard O. Craig, Vice-President; and Dr. Carl K. Ness, Secretary. Dr. Robert W. Kieber was chosen as Treasurer for the 22nd consecutive year.

Dr. Joseph R. Prokop was named to a three-year term on the Board of Censors. Dr. Donald J. Stallard and Dr. Ernest E. Wadlow were elected as MSMA Delegates. Alternate Delegates elected at the meeting are Drs. R. Philip Acuff, Gerald E. Fox, Gordon S. Paulson and Richard V. Riddell. Dr. Robert R. Stuber was named to the Committee on Public Policy and Dr. F. Gregg Thompson, III was chosen as Trustee to 1980. Dr. Randal W. Weed, the present President, was selected as a member of the Executive Secretary Committee.

The newly elected officers and Dr. William B. O'Connor, President-Elect will be installed at the Society's annual meeting in December.

After the election, Northwest Missouri PSRO officers presented a program on PSRO. Those participating were Dr. R. D. Blim, president of Northwest Missouri PSRO; Dr. Fred Fowler, President of Jackson County Medical Society and a PSRO officer; Mr. Allen D. Smith, Executive Secretary of Jackson County Medical Society; and Mr. Robert Watkins, project director for PSRO.

John T. Rogers, M.D., *Secretary*

Grand River Medical Society Meeting

The first fall meeting of the Society was held on September 12 at the Strand Hotel. Eleven members, their wives and two guests were in attendance.

The meeting started with a social hour and dinner.

Dr. Thomas N. Cofer gave an excellent talk about the present development in the PSRO situation and other points of economic interest.

At a short business meeting, it was decided to nominate Dr. Thomas N. Cofer for cooperation with the St. Louis County Medical Society in their request for future cooperation in socio-economical matters.

George Mandler, M.D., *Secretary*

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Mineral Area Medical Society

The Mineral Area Medical Society met at the Farmington Inn on August 1. A brief business meeting was held after the social hour and dinner.

The speaker for the evening was Mr. Henry Mandro, Jefferson City, Director of Health Plan Development for the Missouri Department of Community Affairs. His subject was "Implications and Applications of Comprehensive Health Planning." A lively general discussion followed his presentation.

Members present included Dr. C. H. Appleberry, Jack Mullin, R. A. Huckstep, A. G. Karraker, H. D. Dierker, G. A. Oliver, Jay Tuttle, Metin Arat and C. W. Chastain.

C. W. Chastain, M.D., *Secretary*

IMPROVED ACCIDENT & HEALTH PROGRAMS

The Disability Income Policy sponsored by the Missouri State Medical Association since 1943 has now been made GUARANTEED RENEWABLE and income benefits are available up to $300.00 weekly to members under age 56 subject to acceptance by the Company.

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Continuing Education Coming Events

Oct. 18-20	**Fall Meeting** Missouri Ophthalmological Society Lodge of the Four Seasons, Lake of the Ozarks
Oct. 22-23	**Symposium: Medicine and Religion** Postgraduate Education K.U. School of Medicine, Kansas City, Kan.
Nov. 1-2	**52nd Annual Fall Clinical Conference** Kansas City Southwest Clinical Society Crown Center Hotel
Oct. 31-Nov. 1	**Symposium: Respiratory Therapy** Postgraduate Education K.U. Medical Center, Kansas City, Kan.
Nov. 6	**Pediatric Quizbox Workshops** Continuing Medical Education M.U. Medical Center, Columbia
Nov. 12-15	**Symposium: Internal Medicine** Postgraduate Education K.U. Medical Center, Kansas City, Kan.
Nov. 13-15	**Postgraduate Course: Advances in Clinical Pediatrics** Danciger Institute for Health Sciences; Depts. of Pediatrics of St. Luke's Hospital, Menorah Medical Center and The Children's Mercy Hospital; Missouri Chapter of the American Academy of Pediatrics, the Kansas City Academy of Family Physicians and the MU-KC School of Medicine Children's Mercy Hospital, Kansas City
Nov. 14	**Conference: Child Psychiatry** Continuing Medical Education M.U. Medical Center, Columbia
Nov. 15	**Symposium: Diabetes Mellitus** K.C. Chapter, American Diabetes Association Alameda Plaza Hotel, Kansas City
Nov. 19	**Gastrointestinal CPC With Medical and Surgical Overtones** N.W. Mo. Chapter, Mo. Academy of Family Physicians and K.U. School of Medicine Moila Temple, St. Joseph
Nov. 22-23	**15th Annual M.D. Day** Continuing Medical Education M.U. Medical Center, Columbia
Nov. 22-23	**The Long Weekend: Neurology and Psychiatry** M.U.-K.C. School of Medicine and Division of Continuing Education, K.C. Southwest Clinical Society and the Academy of Health Professions Crown Center Hotel, Kansas City

New Members

Thomas L. Angelo, M.D., 5400 Arsenal, St. Louis, has become a member of St. Louis County Medical Society. Dr. Angelo is a native of Suridwan, India, received his preliminary education at the University of Luknow and his M.D. degree at Poona University in 1965. He specializes in psychiatry.

Jeffrey M. Brick, M.D., 2928 Main, Kansas City, has become a member of Jackson County Medical Society. Dr. Brick is a native of Watertown, N. Y., received his preliminary education at Duke University and his M.D. degree at Washington University in 1970. He specializes in ophthalmology.

John P. Carmody, M.D., 6651 Chippewa, St. Louis, has become a member of St. Louis Medical Society. Dr. Carmody is a native of St. Louis, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1960. He specializes in internal medicine.

Gerald J. Hobson, M.D., 1325 S. Grand Blvd., St. Louis, has become a member of St. Louis County Medical Society. Dr. Hobson is a native of Pittsburgh, Pa., received his preliminary education at the University of Chattanooga and his M.D. degree at the University of Tennessee in 1967. He specializes in ophthalmology.

Harold W. Keairnes, M.D., 2220 Holmes, Kansas City, has become a member of Jackson County Medical Society. Dr. Keairnes is a native of Minneapolis, Minn., received his preliminary education at the University of Minnesota and his M.D. degree at the University of Minnesota in 1957. He specializes in internal medicine.

Ruby R. Mathew, M.D., 5535 Delmar, St. Louis, has become a member of St. Louis County Medical Society. Dr. Mathew is a native of India, received her preliminary education at Holy Cross College and her M.D. degree at Christian Medical College in 1952. She specializes in obstetrics and gynecology.

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L. Beaty Pemberton, M.D., 2220 Holmes, Kansas City, has become a member of Jackson County Medical Society. Dr. Pemberton is a native of St. Joseph, received his preliminary education at the University of Illinois and his M.D. degree at Northwestern University in 1967. He specializes in general surgery.

Yen Shen, M.D., Little Blue & Lee's Summit, Kansas City, has become a member of Jackson County Medical Society. Dr. Shen is a native of China, received his preliminary education at National Defense Medical Center and his M.D. degree at the National Defense Medical Center in 1953. He specializes in internal medicine.

William L. Turano, M.D., 6700 Raytown, Kansas City, has become a member of Jackson County Medical Society. Dr. Turano is a native of Queens, N. Y., received his preliminary education at St. John's College and his M.D. degree at New York Medical College in 1966. He specializes in obstetrics and gynecology.

Pairat Vibulakaopun, M.D., 30 North Allen, Bonne Terre, has become a member of Mineral Area County Medical Society. Dr. Vibulakaopun is a native of Thailand, received his preliminary education at the University of Medical Sciences and his M.D. degree at Chiengmai Medical School in 1966. He specializes in internal medicine.

Primitiva C. Wagan, M.D., 300 S. Grand, St. Louis, has become a member of St. Louis County Medical Society. Dr. Wagan is a native of Baun, Batangas, Philippines, received his preliminary education at the University of the Philippines and his M.D. degree at UE Ramon Magsayay Memorial Medical Center in 1965. He specializes in internal medicine.

Roger A. Willcox, M.D., Gunn Clinic, Versailles, has become a member of Morgan County Medical Society. Dr. Willcox is a native of Columbia, received his preliminary education at Northeast Missouri State College and his M.D. degree at the University of Missouri in 1973. He is in general practice.

From the Medical Schools

ST. LOUIS UNIVERSITY

Fourteen physician's assistants graduated from the St. Louis University School of Nursing and Allied Health Professions in ceremonies held on Friday, August 23. *Sen. William J. Cason* (D), President Pro Tem of the Missouri Senate, addressed the graduates and their families. Commencement climaxed 24 months of study for the graduates.

Dr. Charles E. Berry, associate dean of the School of Nursing and Allied Health Professions, served as master-of-ceremonies, while *Dr. Frances L. Horvath,* project director of the five-year contract with the U. S. Public Health Service which supports the program, distributed diplomas. *Rev. James C. Sunderland,* S.J., chaplain, St. Louis University Hospitals, gave the invocation. Special guests included physicians who had served on the advisory committee and clinical coordinators in the program. During their training, physician's assistants have rotated through the St. Louis University Hospitals, Cardinal Glennon Memorial Hospital for Children, Bethesda Hospital, St. Louis County Hospital and both the Washington and St. Louis University services of St. Louis City Hospitals and St. Louis Veterans Administration Hospitals.

The ceremony was held at Busch Memorial Center.

Elzey M. Roberts, Jr. became assistant vice-president for the St. Louis University Medical Center on September 1. Announcement of his appointment was made by *Dr. George E. Thoma,* vice president for the Medical Center. Mr. Roberts formerly held the position of vice-president of G. H. Walker, Laird Incorporated, an investment banking firm which is a member of the New York Stock Exchange. Prior to that time, he was vice-president of the old *St. Louis Star-Times,* and subsequently president of Radio Station KXOK. Dr. Thoma said Mr. Roberts will assist him in the long-range planning and development of the Medical Center.

The Section of Nuclear Medicine of the Department of Internal Medicine in conjunction with the School of Medicine and the Regional Medical Education Center of the Veterans Administration Hospital, St. Louis, was scheduled to present a Nuclear Medicine Board Examination Review at Stouffer's Riverfront Inn on September 6-8. A total of 115 physicians from across the nation were registered to attend the Review.

Dr. Robert M. Donati, head of the Section of Nuclear Medicine at the St. Louis University School of Medicine, has been appointed Medical Research Program Specialist in Nuclear Medicine and Radiation Research for the Veterans Administration nationally.

Dr. James W. Fletcher, assistant professor of Medicine in the Section of Nuclear Medicine, was elected to membership in the American Federation for Clinical Research.

WASHINGTON UNIVERSITY

While completing more than $25 million in new buildings and renovations last year, Washington University Medical Center provided in excess of $5.4 million in free patient care.

The announcement was made on September 10 at the Medical Center's board of directors annual meeting by Medical Center President *Samuel B. Guze,* M.D.

The board of directors reelected as chairman *Raymond E. Rowland,* who also is chairman of the Barnes Hospital board of directors. Also reelected were President Guze, Washington University vice-chancellor for medical affairs; secretary, *Norfleet H. Rand,* vice-chairman and treasurer of the board of Interco, Inc., and on the board of the Barnard Free Skin and Cancer Hospital; and treasurer, *Joseph F. Ruwitch,* president of Renard Linoleum and Rug Co., and on the board of The Jewish Hospital of St. Louis.

Newly elected were vice-chairman, *Landon Y. Jones,* executive vice-president of Pet Inc., and on the board of St. Louis Children's Hospital; vice-president; *Philip R. Dodge,* M.D., professor and head of the Department of Pediatrics; assistant secretary, *M. Kenton King,* M.D., dean of the School of Medicine; and assistant treasurer, *Hugh Morrison,* assistant dean for financial affairs and assistant vice chancellor for medical affairs.

Entering its second decade as a corporate entity, the Medical Center is comprised of Barnes Hospital, Barnard Free Skin and Cancer Hospital, Central Institute for the Deaf, St. Louis Children's Hospital, The Jewish Hospital of St. Louis and Washington University, including its School of Medicine.

LETTERS to the Editor

To The Editor:

I really appreciate seeing the copy of the editorial, "The Iron Fist," from the *Indianapolis News* in the August, 1974 edition of Missouri Medicine. I have sent a copy of this to the *St. Louis Globe-Democrat.* I wonder if it would be possible to place a copy of this page in the hands of as many newspaper editors in Missouri as possible and even send a copy to every senator and congressman in Washington, as well as in Jefferson City, with a little note that it so well expresses the feelings of the vast majority of us practitioners, notwithstanding the actions of the AMA and the very small vocal minority of full-time professors.

With all kindest regards and best wishes, I am

Sincerely yours,
Wayne O. Gorla, M.D.
St. Louis

In Memoriam

John W. Williams, Jr., M.D., 1227 Roanoke, Springfield, a graduate of Washington University, 1923; member of Greene County Medical Society; age, 78; died Aug. 12, 1974.

Williard Bartlett, Jr., M.D., 6345 Ellenwood Ave., St. Louis, a graduate of the University of Michigan, 1926; member of St. Louis Medical Society; age, 72; died Aug. 14, 1974.

Aaron J. Reiches, M.D., 150 N. Meramec Ave., St. Louis, a graduate of Ohio State University, 1939; member of St. Louis County Medical Society; age, 61; died Aug. 17, 1974.

Lyman D. Brown, M.D., 604 Empire Bldg., Springfield, a graduate of Meharry Medical College, 1938; member of Greene County Medical Society; age, 60; died Aug. 3, 1974.

Richard W. Anderson, M.D., 1001 Romany Rd., Kansas City, a graduate of Georgetown University, 1922; member of Jackson County Medical Society; age, 76; died Aug. 8, 1974.

William J. Stewart, M.D., 909 University Ave., Columbia, a graduate of the University of Pennsylvania, 1927; member of Boone County Medical Society; age, 73; died Aug. 11, 1974.

ANNUAL FALL PANEL DISCUSSION

"THE TREATMENT OF SOFT TISSUE SARCOMAS"

THE ST. LOUIS SURGICAL SOCIETY

Lawrence Ackerman, M.D.
State University of N.Y.
"Guest Moderator"

William Powers, M.D.
St. Louis, Missouri

Jeffrey Gottleib, M.D.
Texas University System
Cancer Center

Francis X. Paletta, M.D.
St. Louis, Missouri

TUESDAY, NOVEMBER 5, 1974—5:30 P.M.

ST. LOUIS MEDICAL SOCIETY AUDITORIUM

All members of the profession are invited.

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

Mme. Marie Curie and M. Pierre Curie carried on their research in an old barn on the outskirts of Paris because they had no funds with which to provide more adequate quarters. Mme. Curie said that the cracks between the boards were so large that they had to stuff them with rags to keep out the cold in the wintertime and they often had to suspend operation on that account.

It is because of this large, airy structure, perhaps, that the radon gas continually emitted by the radium, with which they worked in open dishes, was diluted and dissipated and did not have the harmful effect upon them that it did on so many others who worked with it later in closer quarters.

Overcome by an anemia which overtook her in the pursuit of her work with this dangerous substance, Mme. Curie fell sick to an intercurrent infection with pneumonia and died at Sallauches in the Savoy Alps on July 4, 1934. She was buried in a simple plain oak casket without civil or religious ceremonies beside her husband in the little cemetary at Seeaus, France.

Mme. Curie is survived by two daughters, Eve and Irene. The former has taken up dramatics and music; the latter has followed in her mother's footsteps and expects to carry on the work in research at the Radium Institute.

A movement has been started in France to place the bodies of M. and Mme. Curie in the Pantheon, an unusual honor, especially for one who is not a native of France.

TWENTY-FIVE YEARS AGO

A greater proportion of births in the United States were delivered in hospitals or institutions in 1947 than in any previous year on record, according to the Federal Security Agency. The number of registered live births rose to a peak of 3,699,940 in 1947, and the proportion in hospitals reached a new high of 84.8%. An additional 10.1% of births in 1947 were attended by physicians outside of hospitals and only about one out of 20 births were delivered by a midwife or other nonphysician.

In 1947, almost nine in ten of the white births occurred in hospitals as compared with about one in two nonwhite births. Only 1.5% of white births were attended by nonphysicians, but almost one third of the nonwhite births were delivered by midwives or other nonphysicians. The differences were less marked between residents of urban and rural areas.

Seventy-five physicians attended an evening dinner meeting of the Eighth Councilor District at Wilders Cafe in Joplin on July 12. The Jasper County Medical Society was host. Wallis Smith, M.D., President of the MSMA, gave the opening talk. Mr. Ray McIntyre, Field Secretary for the MSMA, spoke briefly on present efforts of the administration in Washington to bring physicians under the Social Security Act via House Resolution #2893. It was good to have our good friend, Dr. Homer Kerr, back with us again and his few remarks were appreciated.

TEN YEARS AGO

Mr. Charles H. Yalem has given $50,000 to Washington University School of Medicine. The gift will support research in the Department of Psychiatry and has been established as the Charles and Florence Yalem Research Fund in Psychiatry, for the donor and his wife. Mr. Yalem, who is president of the Aetna Finance Company in St. Louis, has been a generous contributor to University activities.

A Papal Order of Merit was awarded recently to Harry K. Purcell, M.D. of St. Louis. Dr. Purcell, who spent four years at the Holy Family Hospital in New Delhi, India, received a gold medal and the Order of Pro Ecclesia et Pontifice from the Archbishop of Delhi.

The Missouri Society of Internal Medicine installed Blaine Z. Hibbard, M.D., Kansas City as president at the recent annual meeting held at the Lake of the Ozarks.—Frank McDowell, M.D. of St. Louis recently was elected chairman of the Board of Trustees at Drury College in Springfield.

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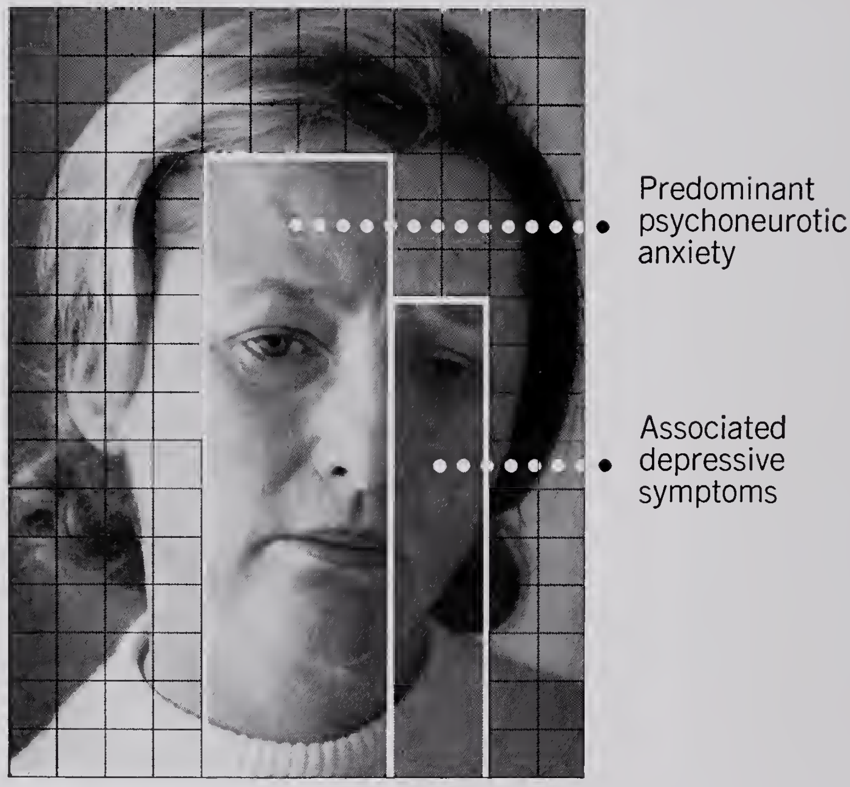
April 17-20, 1975, St. Louis

Both often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require increased dosage of standard
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may be associated with temporary increase in frequency and/or severity of
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gestion of alcohol and other CNS depre
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those with barbiturates and alcohol) h
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respond to one

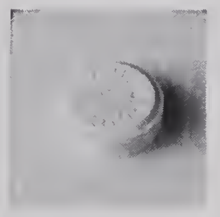
According to her major iptoms, she is a psychoneu- c patient with severe iety. But according to the cription she gives of her ings, part of the problem y sound like depression. s is because her problem, hough primarily one of ex- sive anxiety, is often accom- ied by depressive symptom- logy. Valium (diazepam) provide relief for both—as excessive anxiety is re- ed, the depressive symp- is associated with it are also n relieved.

There are other advan- es in using Valium for the nagement of psychoneu- c anxiety with secondary ressive symptoms: the chotherapeutic effect of ium is pronounced and id. This means that im- vement is usually apparent he patient within a few s rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



Valium®
(diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

veillance because of their predisposi- to habituation and dependence. In gnancy, lactation or women of child- ring age, weigh potential benefit nst possible hazard.

cautions: If combined with other psy- tropics or anticonvulsants, consider efully pharmacology of agents em- ed; drugs such as phenothiazines, cotics, barbiturates, MAO inhibitors other antidepressants may potentiate ction. Usual precautions indicated in ents severely depressed, or with latent ression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Missouri Medicine

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NEWS ROUND - UP

November, 1974

Busy Session is anticipated

"Surgicenter" legislation planned

"It's perhaps inappropriate to say we physicians dread to see a lawmaking body — federal or state — go into Session, but it does appear that our particular profession attracts an inordinate amount of attention from these people."

And, added Dr. John I. Matthews, MSMA Legislative Chairman, in a talk before the MSMA Auxiliary Fall Conference in Springfield, "I can assure you that 1975 will offer no change . . . if that's assuring."

In outlining the Association's state legislative program for 1975, Dr. Matthews said the MSMA plans to support several progressive and needed bills and will oppose some measures which the Association believes detrimental to medicine.

"In a positive nature," stated Dr. Matthews, "we intend to be in the forefront in seeking legislation to cover surgicenters, a seat belt law and measures which will provide appropriate insurance coverage for mental illness and complete maternity care."

"The licensing of surgicenters could provide a vehicle which would serve to lower the cost of medical care — a subject which attracts many headlines and many legislative bills," said Dr. Matthews.

An outline of the MSMA legislative program follows: To meet proposed licensing requirements, a "surgicenter" would have to have an organized staff of physicians and permanent facilities equipped and operated primarily for the purpose of performing surgical procedures. Continuous physician and registered nurse services must be available whenever a patient is in the facility. Also, the center could not provide accommodations for patients to stay overnight.

As directed by the 1974 MSMA House of Delegates, the Legislative Committee intends to seek support for the passage of a seat belt law. In a related area, the House also directed the Association to support legislation designed to discourage driving while intoxicated.

The initial draft of legislation dealing with insurance coverage for mental illness has been approved by the MSMA Council in response to Resolutions from the House of Delegates. The draft was prepared by the Legislative Committee in cooperation with the Missouri Psychiatric Association.

A model bill from the American College of Obstetricians and Gynecologists on complete maternity benefit coverage under health and accident policies has received Association endorsement. The bill provides that a pregnancy which begins while the insurance is in force should be covered until the termination of the puerperium and until the newborn infant is discharged from the hospital to home care.

In the 1974 Session of the General Assembly, the MSMA was instrumental in obtaining passage of a bill which requires group insurance policies to provide coverage to newborns from the moment of birth rather than after a 14-day waiting period.

Another bill of interest likely to be introduced in this Session would provide for the printing of the Uniform Anatomical Gift Act on the reverse side of Missouri Motor Vehicle Operators and Chauffeurs Licenses. The Association was successful in gaining passage of the Uniform Anatomical Gift Act a few years ago and the proposed bill would facilitate donors usage of the previous legislation.

Some bills which may be introduced and are likely to draw MSMA opposition include an acupuncture bill with inadequate rules and regulations; a measure designed to extend the statute of limitations on physicians; and, as usual, bills aimed at furthering the scope of chiropractice.

"Our opposition to bills such as these has been successful the past few years," said Dr. Matthews.

However, he added, "when we oppose bills we not only need good arguments, we also need a 'show of strength.' I only hope that if it becomes necessary, many of you here will be willing to contact your Legislators regarding your position on unfavorable measures."

African Adventure, Seminar is scheduled in February

Members were recently mailed information concerning MSMA-sponsored "African Adventure and Medical Seminar."

The tour, which departs at Kansas City and St. Louis on Feb. 25, 1975, features a two-week visit to Africa — seven days in Morocco and seven days in Mairobi.

Highlights in Morocco include Rabat, a city of ancient walls, splendid old gateways and delightful public gardens, and Casablanca, Africa's famed international city of intrigue.

Nairobi, the capital of Kenya, is in the heart of East Africa and offers a wide variety of attractions ranging from the plains of Serengeti to Mount Kilimanjaro.

The medical seminar will offer a unique opportunity to learn of developments in the medical field in other parts of the world. Lectures will be presented by an outstanding staff of physicians and educators who are leading experts in their fields. The AMA will credit this continuing medical education seminar program hour for hour toward the Physician's Recognition Award under Category Two.

For further information of the "African Adventure and Medical Seminar," write to the Missouri State Medical Association, Box 1028, Jefferson City, Mo. 65101.

Assailant really knew how to hurt a girl!

Sometimes things are better when they are left unsaid:

That the following Associated Press article out of Tulsa, Oklahoma, for example:

A rape charge was reduced to assault yesterday in District Court after the alleged victim testified.

District Court Judge Raymond Graham questioned the woman:

"What did he tell you to do?" the judge asked.

"He told me to go into the bedroom."

"And then what?" the judge asked.

"He told me to undress."

"Did you?"

"I did. He looked at me and told me to get dressed again."

MAFP to meet Nov. 8-10

The Missouri Academy of Family Physicians will hold its 26th Annual Scientific Assembly at Tan-Tar-A Resort, Lake of the Ozarks, Nov. 8-10.

Planned activities include the President's Annual Banquet at 7:30 p.m. Saturday, Nov. 9. The incoming President is Lois C. Wyatt, M.D., of Kirkwood, who will succeed Walter Jack Stelmach, M.D., of Kansas City.

Membership ↗ Up!

Membership in the Missouri State Medical Association has reached a record total during 1974.

With two months remaining in the current membership year, the number of MSMA members has surpassed 4,550, a gain of 81 new members over the total of 4,469 members reported on December 31, 1973. It is likely the final 1974 figure will be slightly higher than the present figure.

A breakdown of the total membership shows 112 Junior Members, 418 Honor Members, and 4,020 Active Members.

Comparable figures at the end of 1973 listed 105 Junior Members, 407 Honor Members, and 3,957 Active Members.

Missouri physicians who are paid members of the American Medical Association have also increased in 1974. The state topped its 1973 total of 3,700 AMA members in September, but the latest figures are not available at present. A complete rundown of membership figures will be published following the December 31 audit.

•••Notes about members•••

Dr. Washburn honored

J. Loren Washburn, M.D., of Versailles, was honored at the September meeting of the Cole County Medical Society.

Dr. Washburn, who chose not to seek another term as Delegate to American Medical Association, was presented a plaque in appreciation of his many years of service to the Fifth Councilor District of the MSMA as a Councilor and a Delegate.

Dr. Stelmach to Board

Walter Jack Stelmach, M.D., of Kansas City, current President of the Missouri Academy of Family Physicians, has been elected to the Board of Trustees of the American Academy of Family Physicians.

Dr. Frueh is selected

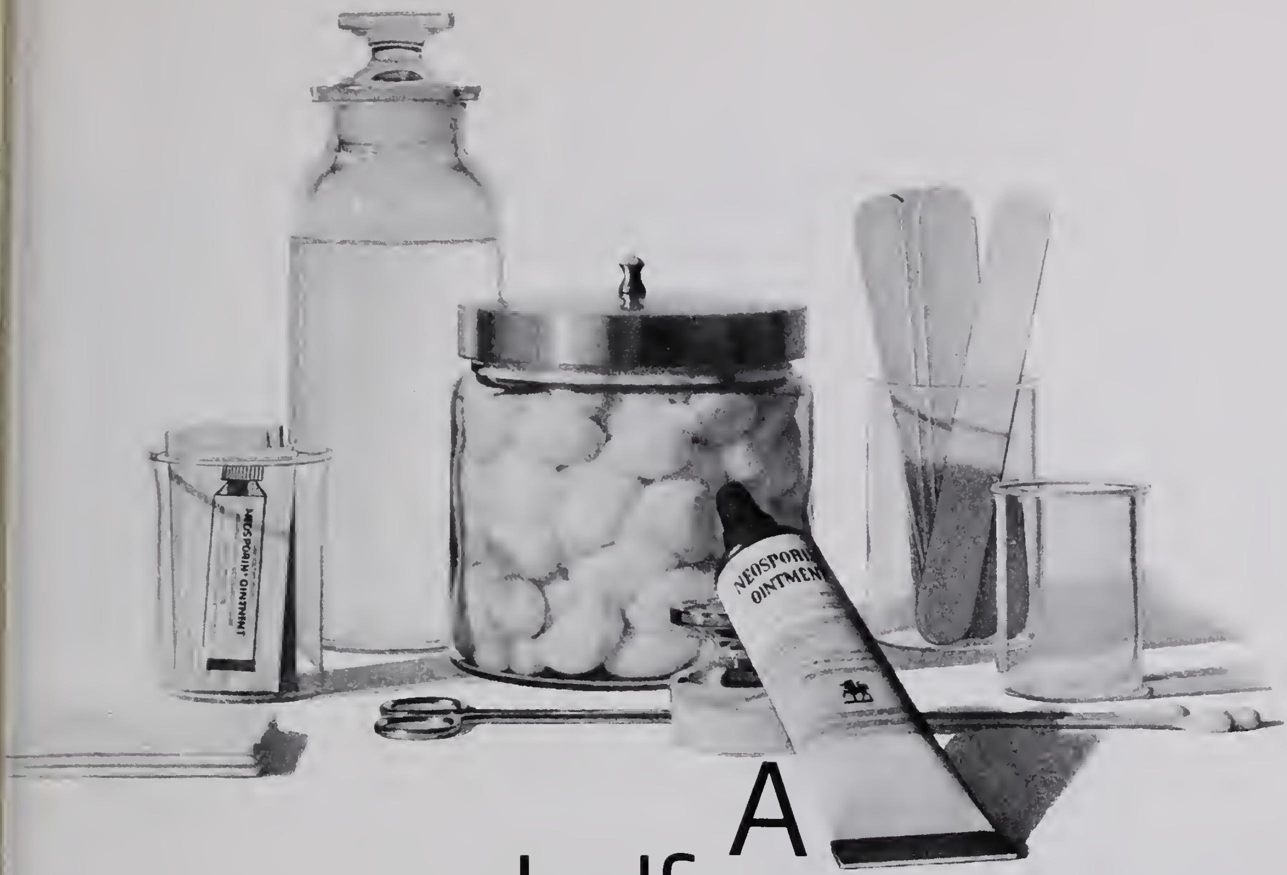
Bartley R. Frueh, M.D., of Columbia, has been selected as President-Elect of the American Society of Ophthalmic Plastic Surgery.

Dr. Frueh is in private practice in Columbia and is clinical professor of ophthalmology at the University of Missouri-Columbia School of Medicine.

Dr. Cope discusses MSMA

James C. Cope, M.D., President, was the principal speaker at the MSMA Eighth District meeting in Joplin on October 8. Physicians from the District's 15-county area in Southwest Missouri attended the meeting.

Dr. Cope discussed current and future activities of the MSMA.



A
half-ounce
of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs. In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

IDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic ierapy for topical infections, primary or secondary, due to susceptible organms, as in: • infected burns, skin grafts, surgical incisions, otitis externa primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts nd wounds accidentally incurred, its use may prevent the development of fection and permit wound healing.

ONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum perforated. This product is contraindicated in those individuals who have iown hypersensitivity to any of the components.

ARNING: Because of the potential hazard of nephrotoxicity and ototoxicity ue to neomycin, care should be exercised when using this product in treating xtensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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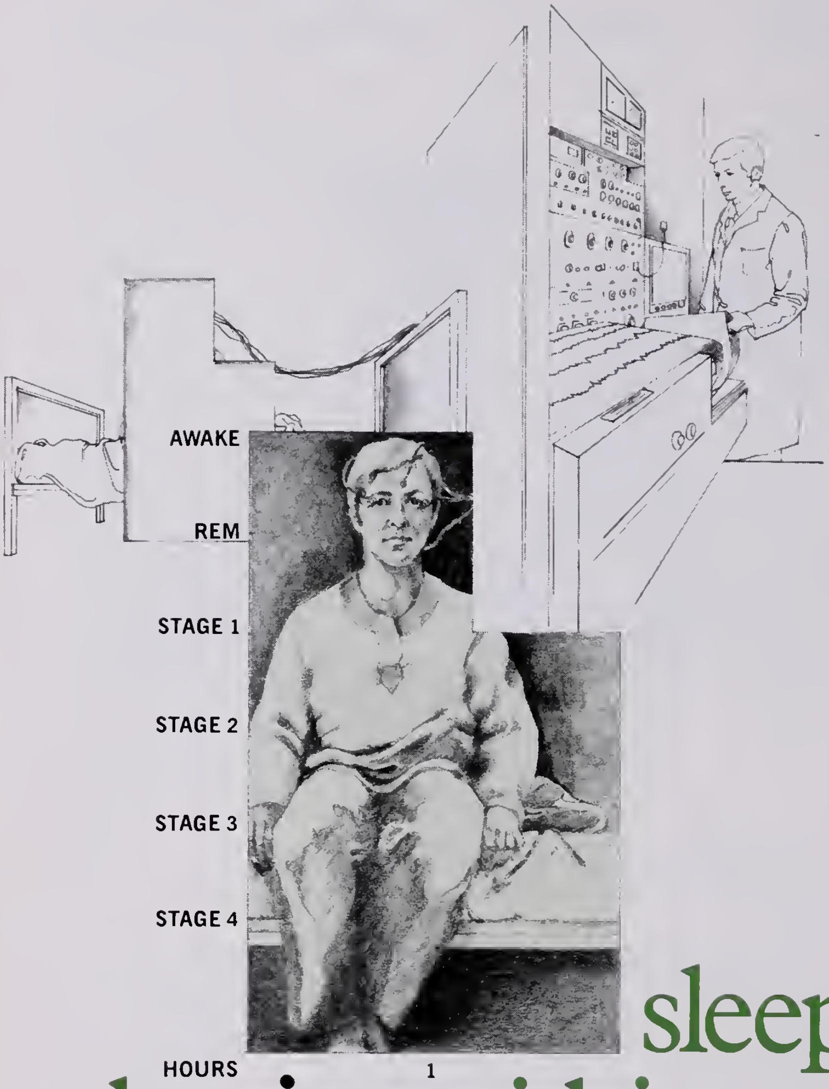


sleep begins within 17 minutes, on average...

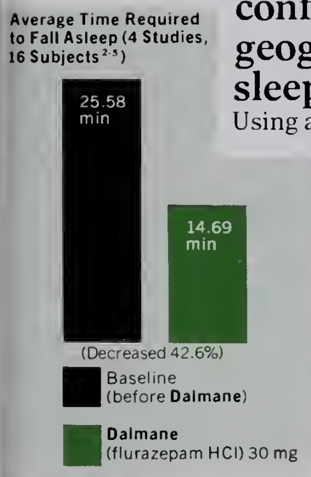
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

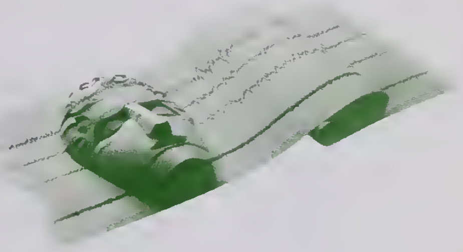
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®

(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

---

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

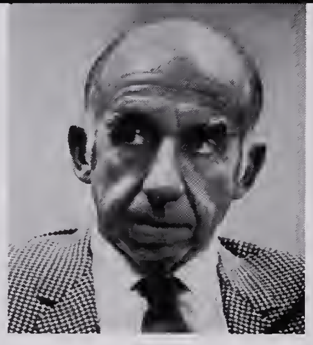
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I ar very much in favor of the detail me I meet. Most of them are knowledg able about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community
Health and Preventive
Medicine, and Dingman
Professor of Cardiology
Northwestern University
Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likeliho on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

le a Source of Information?

Yes, with certain reservations.
e average sales representative
s a great fund of information
out the drug products he is re-
onsible for. He is usually able to
swer most questions fully and
elligently. He can also supply
prints of articles that contain a
eat deal of information. Here,
, I exercise some caution. I usu-
/ accept most of the statements
d opinions that I find in the
pers and studies which come
m the larger teaching facilities.
oes without saying that a physi-
n should also rely on other
urces for his information on
armacology.

ining of Sales Representatives

Ideally, a candidate for the
sition as a sales representative
a pharmaceutical company
uld be a graduate pharmacist
o has a questioning mind. I don't
nk this is possible in every case,
d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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pacity they are indeed useful;
rticularly in the fact that they
seminate broadly based educa-
nal material and serve not just
"pushers" of their drugs.

e Other Side of the Coin

Obviously, the pharmaceuti-
companies are not producing all
s material as a labor of love—
y are in the business of selling
ducts for profit. In this regard
ambitious and improperly moti-
ed sales representative can
rt a negative influence on the
cticing physician, both by pre-
nting a one-sided picture of his
duct, and by encouraging the
ctitioner to depend too heavily
drugs for his total therapy. In
se ways, the salesman has often
torted objective reality and
dermined his potential role as an
cator.

e Industry Responsibility

Since the detail man must be
information resource as well as
epresentative of his particular
armaceutical company, he
uld be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical
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P·M·A

Missouri Hospital Facilities (1971): Factors Influencing Utilization

By
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THE INTENT of this report is two-fold. The first is to present factual information concerning Missouri's hospitals. Questions that will be addressed include, "What kinds of hospitals are located within Missouri? How many are there? Where are they located and how many beds do they have?" The second purpose of the report is to review utilization patterns and to identify a number of factors that affect hospital utilization. In the same way that our previous report on physicians was intended to be the first of a series on health manpower, this report is intended to be the first of a continuing series on Missouri's hospital facilities. Although not its only purpose, this report is issued by the Missouri Center for Health Statistics to assist planners and evaluators of hospital construction proposals.

In Missouri as elsewhere in the nation, hospitals are a key factor in the total health care system. Planning of these highly visible facilities has become a matter of general public concern. Many factors account for the increased attention hospitals now receive, but cost has been of special concern. Over the past two decades, national medical care costs have increased more than five times. While a high proportion of this increase must be attributed to inflation, federal wage and hour laws and Medicare requirements, hospital costs have escalated at a faster rate than other items in the consumer price index. One reason for increased hospital costs is that more is being done for patients now than in 1950 and in 1960, e.g., via intensive care units, arterial grafts, open heart operations and other costly and sophisticated methods of treatment.

However, nearly 40% of the $75 billion spent nationally for health care in 1971 was for payment of hospital services—$29.6 billion.[1] Hospital costs per patient day in community hospitals increased on a nationwide basis from $16 in 1950 to approximately $32 in 1960 and then to more than $92 in 1971.[2] Precisely comparable figures are not available fo Missouri hospitals, but there is little reason to be lieve that Missouri's costs differ greatly from th nation's. Per diem charges for people covered b Kansas City Blue Cross, for example, average slightly more than $91 for the 1971 calendar year.

The increase in hospital costs has led to an in creasing demand for better use of existing hospita facilities by Congress and state and local legislators by insurance and other third-party payers and b the health care community itself. At the same time however, demand continues for modernization an expansion of present hospitals. Development of ne hospitals is being sought in areas where hospital are not now considered accessible by the genera public, as in some rural areas and in the fringes o rapidly-growing suburban areas. In large urba areas, the population has moved away from the area containing an appreciable number of hospital beds It is contended by some that hospital accessibility i limited because patients' families and doctors are reluctant to enter hospitals in deteriorated sections of the metropolitan areas.

In any event, these contradictory concerns have resulted in sharp debate in many communities about the advisability of expanding present hospital facilities, of developing new facilities or of relocating existing facilities. Improving accessibility may require, or seem to require, expansion of present facilities or building of new facilities. Yet, escalating costs would seem to point to continued or more intensive utilization of existing facilities rather than new construction.

Planning for hospital facilities is complex. Present utilization patterns are not completely known and future needs are not entirely predictable. This report demonstrates that the need for hospital services is determined by many different factors. Users are cautioned that this report does not contain sufficient information to make definitive determinations as to whether a specific area has too many or too few hospitals or hospital beds or whether the services provided are adequate for the area being served. Neither does it address the important question of whether existing facilities in any area are being utilized in the best way to meet the particular needs of that area. As will be seen, the age structure of the population, population density variations between urban and rural areas, advances in medicine and other factors interact and all influence hospital use.

No standard plan or formula that can be applied to an area or to all hospitals is available for hospital planners. Attempts have been made to develop such standards. For example, prior to 1964, the federal Hill-Burton program, through which funding for certain hospital construction projects is available, used the following minimum bed-population ratios to establish priorities: 2.5 beds per 1,000 population for rural hospital service areas, 4.0 beds per 1,000 population for "district" or "intermediate" areas and 4.5 beds per 1,000 population for metropolitan or "base" areas. The federal government discarded this method in 1964 because of recognition that such simple ratios do not adequately describe need.

Priorities in the federal Hill-Burton program are now determined by a more complex formula. In Missouri, general bed needs are projected by dividing the patient days of care performed by general hospitals by the current population of the area. This quotient indicates the present use rate of the area. The use rate is multiplied by the projected population of the area for the year in question and then divided by 365 to indicate the estimated average daily census. The estimated daily census is divided by .85 to indicate the number of general beds that will be needed in the area.[4]

The underlying assumption of this formula is that "need" is measured by and equivalent to "demand." Factors other than need, however, affect demand. Weil, reporting on studies of hospitals and health needs in several Missouri areas, found that although most people use the nearest facility, as many as 35% will leave the immediate area for hospital services and physician services when a local facility is available, especially if the local area has an obsolete hospital or a medical staff made up almost solely of general practitioners. He concluded, "Patient outmigration is related to the quantity and quality of health services in the immediate area."[5]

This study represents the second major data collection and analysis effort of the Missouri Center for Health Statistics, which is jointly sponsored by the State Board of Health and the Governor's Advisory Council for Comprehensive Health Planning.

Reprints of this report may be obtained from the Missouri Center for Health Statistics, Missouri Division of Health, Jefferson City, Mo. 65101

In Vermont, application of a formula based on utilization resulted in recommending the largest increase in beds for the area that already had both the highest rate of beds per 1,000 population and the highest rate of patient days per 1,000 population.[6] Thus, this more complex formula has its faults, since low utilization—regardless of the reasons—leads to low priority and high utilization leads to high priority. The Vermont study suggests that the emphasis on present demand increases disparity among areas. Patient residence is thus one important factor which should be taken into account in hospital planning, but, obviously it cannot be used alone. This report will point out other factors which need to be examined to determine local needs more accurately.

We have attempted to present Missouri hospital data in a meaningful and usable manner. But definitions of "hospitals," "beds" and classification of types of care vary from one source to another. Some widely-used national publications separate hospitals into "general" hospitals and "specialty" hospitals, and they describe the availability of "acute care" facilities by simply counting beds in the general hospitals. This method ignores the fact that a number of these beds, particularly in the larger hospitals, may be reserved for other types of care. Increasingly, psychiatric patients and those requiring long-term care are being treated in general hospitals frequently in areas of the building specifically set aside for these purposes. Since these beds and beds in children's hospitals, pediatric units of general hospitals and maternity units are not available to infectious or other adult patients, the value of compiling gross bed totals is, to a great extent, questionable. Recognizing that hospitals cannot be precisely differentiated on the basis of services provided, our discussion of the availability of medical-surgical, pediatric and maternity care is based on the bed complements dedicated to these services,

TABLE 1

HOSPITALS AND BEDS BY TYPE OF OWNERSHIP OR CONTROL
MISSOURI, 1971

Ownership or Control	*Number* HOSPITALS	BEDS	*Percent* HOSPITALS	BEDS	*Average Size*
Voluntary—nonprofit	95	18,352	54.9	54.9	193
Local government	46	4,918	26.6	14.7	107
Proprietary	21	1,485	12.1	4.4	71
State government	11	8,682	6.4	26.0	789
Missouri total	173	33,437	100.0	100.0	194

regardless of the type of hospital in which the beds are located.

Until nationally accepted standard definitions are provided, exact comparisons cannot be made between Missouri and the nation or Missouri and other states. We believe, however, that general comparisons to other American Hospital Association and federal government studies are possible.

Hospitals in Missouri: an Overview

At the end of 1971, there were 173 nonfederal hospitals in Missouri. These contained a total of 33,437 beds for a rate of approximately 7.1 beds for each 1,000 Missouri residents. Comparison with similar data for 1960 shows that the number of hospitals in Missouri has decreased 7%, but the total number of beds has changed only slightly. In that year, Missouri contained 186 nonfederal hospitals with a total bed complement of 33,612, for a rate of 7.8 beds per 1,000 population.[7]

As we have indicated, total bed counts do not adequately describe facilities or the availability of hospital care. Other comparisons illustrate this clearly. In 1960, for example, one third of the state's total beds were in the five large mental institutions. By 1971, these same institutions contained only about one fifth of the total number of beds.

In 1960, there were 20,059 beds in general hospitals for a rate of 4.6 beds per 1,000 population. By 1970, the number of beds in general hospitals had increased to 25,044 and the rate had risen to 5.3 per 1,000 population.[*] From these admittedly limited data, however, we can conclude that the trend in the past decade in Missouri has been toward fewer but larger general hospitals.

It also should be noted that hospitals in the major Missouri metropolitan areas of St. Louis and Kansas City serve substantial portions of Illinois and Kansas. Hospitals in St. Joseph and Joplin also serve many out-of-state residents. While there is some "exporting" of Missouri residents to such out-of-state cities as Memphis, Tenn. and Quincy, Ill., inflow of nonresidents is, we believe, greater than outflow of residents for hospital services.

Conversely, as will be seen in the discussion of hospital utilization patterns in northwestern Missouri, this is not necessarily true for particular regions of the state. For the state as a whole, however, the number of births and deaths recorded, i.e., that occurred in Missouri has consistently exceeded the number of births to and deaths of Missouri residents.[8] While this does not definitely prove greater inflow for all hospital services, it does support our assumption.

Ownership of Missouri Hospitals

Missouri's 173 hospitals and 33,437 beds have been classified by type of ownership or control in Table 1. In 1971, 95 or slightly more than half of the hospitals (54.9%) were operated on a voluntary-nonprofit basis. This group also provided the same percentage relationship of hospital beds to the state total. The average number of beds per hospital for this group was 193, which was nearly identical to the state average of 194 beds.

The next largest classification includes hospitals owned and operated by local units of government. Six of these were operated by hospital districts, 28 by counties and 12 by cities for a total of 46. These hospitals contained a total of 4,918 beds or 14.7% of the total. Average size of these hospitals (107 beds) was somewhat smaller than the state average.

Proprietary hospitals comprised the third largest group in terms of number of hospitals (21). These represented 12.1% of the state's hospitals, but only 4.4% of the total beds. The average size of these facilities was the lowest of the four groups at 71 beds per hospital.

The 11 state-operated hospitals are the largest with an average of 789 beds. This group includes the five large mental hospitals.

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[*] It must be remembered that counting beds in general hospitals permits only gross measurement of availability of services. Our source for 1960 data gives the total bed complement, but shows services only as "general" or "chronic" care.

MISSOURI COMPARED WITH THE UNITED STATES

Missouri contains approximately 2.3% of the United States population, approximately 2.4% of all nonfederal hospitals and 2.4% of all nonfederal hospital beds. Further comparison of Missouri's hospital facilities with those of the United States shows that Missouri generally differs little from national averages.

For example, Missouri's nonfederal hospitals provided a total of 7.1 beds for each 1,000 population in 1971. This compares with a figure of 6.6 for the nation. Similarly, the Missouri rate of general care beds was 4.9 compared to 4.4 for the United States.[9]

Missouri has a smaller percentage of hospitals with fewer than 50 beds but a larger percentage of those with 50 to 99 beds than does the United States, as shown in Table 2. Large hospitals of 500 beds or more form a larger percentage of the total in Missouri than in the nation. Five of the 16 Missouri hospitals in this group were psychiatric (31.3%), compared to 198 of 480 (41.3%) for the nation. The average size of Missouri hospitals tends to be slightly larger than for the United States—193.3 compared to 186.8.

TABLE 2

BED SIZE OF NONFEDERAL HOSPITALS
UNITED STATES AND MISSOURI
1971

	Number of Hospitals		*Percent of Hospitals*	
Bed Size	U. S.	MISSOURI	U. S.	MISSOURI
Less than 50 beds	2,213	33	30.2	19.1
50-99	1,778	56	24.3	32.4
100-199	1,508	36	20.6	20.8
200-299	701	17	9.6	9.8
300-499	643	15	8.8	8.7
500 beds or more	480	16	6.5	9.2
Total	7,323	173	100.0	100.0
Average bed size	186.8	193.3		

United States data from *Health Manpower and Health Facilities*, 1972-73, DHEW Publication No. (HSM) 73-1509.

In terms of ownership, Missouri again closely parallels the United States. Identical percentages of hospitals (32.9%) are operated by governmental units (Table 3) with the percentages for proprietary and nonprofit ownership similar to those for the nation.

TABLE 3

OWNERSHIP OF NONFEDERAL HOSPITALS
UNITED STATES AND MISSOURI
1971

	Number of Hospitals		*Percent of Hospitals**	
Ownership	U. S.	MISSOURI	U. S.	MISSOURI
State or local government	2,412	57	32.9	32.9
Proprietary	1,071	21	14.6	12.1
Nonprofit	3,840	95	52.4	54.9
Total	7,323	173	100.0	100.0

United States data from *Health Manpower and Health Facilities*, 1972-73, DHEW Publication No. (HSM) 73-1509.
* May not add to 100% because of rounding.

HOSPITALS BY REGIONAL PLANNING AREAS

The Regions of Missouri

Material in this report is presented in accord with the regionalization concept developed by the Missouri Department of Community Affairs under federal guidelines and adopted by Executive Order for planning purposes. Regional Planning Commission areas, to the maximum extent possible, are based on similar shopping and commercial patterns and similar geographic features. Most regions have an urban center with major business concentrations.

In Missouri, establishment of the 20 Regional Planning Commission areas began in 1966 and continued through 1969, when the present boundaries were fixed (Fig. 1). Each of Missouri's 114 counties and the independent city of St. Louis were assigned to one of the 20 regions. Most regions contain five or more counties, but some have as few as three and one has as many as ten.

For the two largest metropolitan areas, St. Louis to the east and Kansas City to the west, regional boundaries are the same as the Missouri portion of the corresponding Standard Metropolitan Statistical Areas as defined by the Bureau of the Census. Three other regions contain such metropolitan areas: They are Lakes Country (Springfield), Mid-Missouri (Columbia) and Mo-Kan Bi-State (St. Joseph). These regions are considered "metropolitan" for this report, and the data are so identified, even though they contain rural counties as well as densely urbanized counties. Lakes Country, for example, is shown as a metropolitan region even though nine of the counties in the region are rural. The Appendix (available in reprints), which lists

GENERAL CARE HOSPITAL BEDS
(MEDICAL-SURGICAL, OBSTETRIC AND PEDIATRIC)
Per 1,000 Population
1971

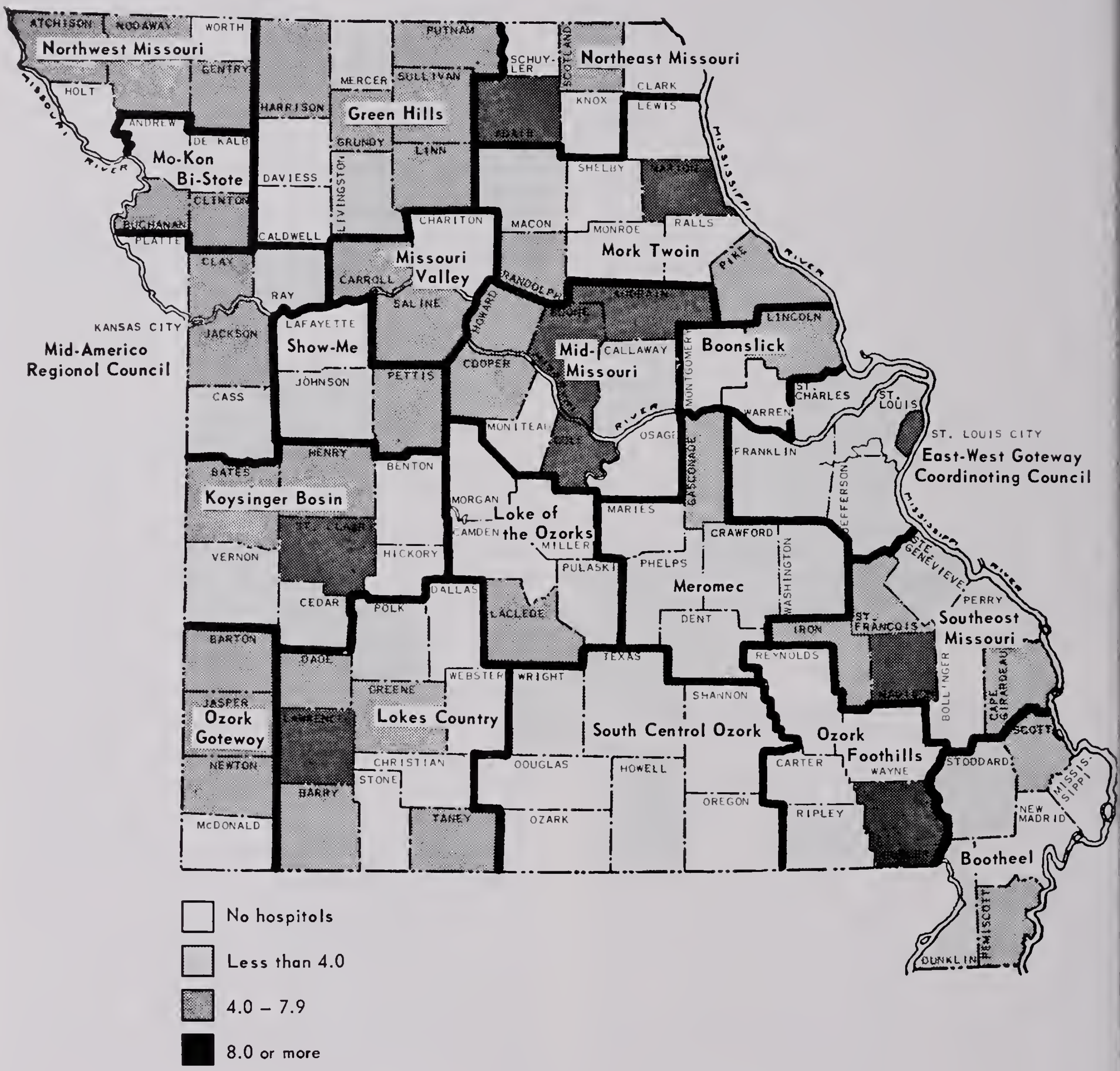

Fig. 1

all of Missouri's hospitals, shows separate totals for these major cities.

Comparison of Metropolitan and Nonmetropolitan Regions

Of Missouri's 33,437 total hospital beds, 23,019 (68.4%) have been identified by the hospitals as general or acute-care beds which are defined for this report as medical-surgical, maternity or pediatric. On a statewide basis, this provides 4.9 acute-care beds for each 1,000 Missouri residents. Rates by region within Missouri vary considerably, however, as shown in Table 4. This is particularly true for the 15 nonmetropolitan regions. Although the total nonmetropolitan rate is 4.0 beds per 1,000 population, the range extends from a low of only

TABLE 4

DISTRIBUTION OF GENERAL HOSPITAL BEDS BY REGIONAL PLANNING COMMISSION AREAS MISSOURI, 1971

Regional Planning Commission Area	*Estimated 1971 Population*	*Number of General Hospitals*	*Number of General Care Beds*	*Average General Care Complement*	*General Care Beds Per 1,000 Population*
Metropolitan Regions					
East-West Gateway	1,823,000	33	9,151	277.3	5.0
Mid-America	876,600	25	4,376	175.0	5.0
Lakes Country	293,800	11	1,684	153.1	5.7
Mid-Missouri	227,400	10	1,613	161.3	7.1
Mo-Kan Bi-State	120,200	4	624	156.0	5.2
Nonmetropolitan Regions					
Northwest Missouri	50,600	3	209	69.7	4.1
Green Hills	87,900	8	396	49.5	4.5
Missouri Valley	47,800	3	211	70.3	4.4
Northeast Missouri	46,500	4	305	76.3	6.6
Mark Twain	118,400	6	518	86.3	4.4
Boonslick	39,500	1	84	84.0	2.1
Ozark Gateway	137,900	8	760	95.0	5.5
Kaysinger Basin	85,300	8	375	46.9	4.4
Show-Me	96,900	4	346	86.5	3.6
South Central Ozarks	89,800	4	176	44.0	2.0
Meramec	92,800	5	268	53.6	2.9
Lake of the Ozarks	111,300	2	148	74.0	1.3
Southeast Missouri	144,100	9	775	86.1	5.4
Bootheel	162,600	6	547	91.2	3.4
Ozark foothills	64,600	4	453	113.3	7.0
Totals					
Metropolitan total	3,341,000	83	17,448	207.7	5.2
Nonmetropolitan total	1,376,000	75	5,571	74.3	4.0
Missouri total	4,717,000	158	23,019	144.8	4.9

1.3 in the Lake of the Ozarks region to a high of 7.0 for Ozark Foothills. Three areas, namely Boonslick, South Central Ozark and Lake of the Ozarks, are below the 2.5 rate once used under the Hill-Burton program to measure "adequacy" for nonmetropolitan areas.

Metropolitan areas and regions, such as Mid-Missouri which contains a metropolitan county, have a 30% higher total rate (5.2) than nonmetropolitan areas (4.0), and show less variation among regions with one exception. The bed complement used in computing Mid-Missouri's rate of 7.1 includes 533 beds in two state-owned hospitals, the University of Missouri Medical Center and Ellis Fischel State Cancer Hospital (EFSCH). It was never planned or intended that these two facilities serve only the Mid-Missouri region. The Medical Center, established as the teaching facility for the University medical school, is available to all Missourians for diagnostic studies as well as surgical and therapeutic procedures. EFSCH was originally established to care for medically indigent cancer patients in the entire state.[10] During the 1971-1972 fiscal year, only 13.4% of the patients admitted to EFSCH resided within the Mid-Missouri region. Discharge statistics from the Medical Center for the same period of time show that only 34.9% of the patients discharged were residents of that region. Reducing the bed complement of these two hospitals to reflect only those beds being utilized by residents of the region would change the rate to approximately 5.5 per 1,000 population. With this adjustment, the range for the metropolitan regions is from 5.0 beds per 1,000 population for East-West Gateway to 5.7 per 1,000 for Lakes Country.

TABLE 5

UTILIZATION OF GENERAL HOSPITAL BEDS BY REGIONAL PLANNING COMMISSION AREAS MISSOURI, 1971

Regional Planning Commission Area	*Number of General Care Discharges*	*Average Daily Census*	*General Care Discharges Per 1,000 Population*	*Occupied General Care Beds Per 1,000 Population*	*Occupancy Rate for General Car Beds*
Metropolitan Regions					
East-West Gateway	302,364	7,565.2	165.9	4.1	82.7
Mid-America	157,678	3,431.5	179.9	3.9	78.4
Lakes Country	56,249	1,376.7	191.5	4.7	81.8
Mid-Missouri	52,127	1,247.5	229.2	5.5	77.3
Mo-Kan Bi-State	22,023	519.1	183.2	4.3	83.2
Nonmetropolitan Regions					
Northwest Missouri	6,908	150.3	136.5	3.0	71.9
Green Hills	13,391	291.1	152.3	3.3	73.5
Missouri Valley	5,054	133.3	105.7	2.8	63.2
Northeast Missouri	8,219	181.6	176.8	3.9	59.5
Mark Twain	16,847	339.8	142.3	2.9	65.6
Boonslick	2,784	48.0	70.5	1.2	57.2
Ozark Gateway	24,085	574.9	174.7	4.2	75.6
Kaysinger Basin	13,412	280.6	157.2	3.3	74.8
Show-Me	13,749	271.5	141.9	2.8	78.5
South Central Ozark	6,260	113.4	69.7	1.3	64.4
Meramec	12,226	216.8	131.7	2.3	80.9
Lake of the Ozarks	5,498	95.3	49.4	0.9	64.4
Southeast Missouri	30,667	575.1	212.8	4.0	74.2
Bootheel	20,733	397.5	127.8	2.4	72.7
Ozark Foothills	17,549	341.0	271.7	5.3	75.3
Totals					
Metropolitan total	590,441	14,139.1	176.7	4.2	81.0
Nonmetropolitan total	197,382	4,010.2	143.4	2.9	71.9
Missouri total	787,823	18,149.3	167.0	3.8	78.8

Metropolitan regions in general have higher rates of beds per 1,000 population than do nonmetropolitan regions, and the difference is even more striking when "occupied" beds are considered. Table 5 shows that the rate of occupied beds per 1,000 population for the metropolitan regions is 4.2. This is 44.8% higher than the 2.9 rate for the nonmetropolitan regions. Some of the nonmetropolitan regions containing relatively large cities closely resemble the metropolitan region in terms of hospital facilities. Two examples are Ozark Gateway (Joplin) with 4.2 and Ozark Foothills (Poplar Bluff) with 5.3.

The most commonly-used measure of hospital use is the occupancy rate—the percentage of available beds which are actually occupied on the average day. Occupancy rates have value for planners for several reasons. They are readily available, they are easy to compute, they are widely recognized as measures of utilization and "standards" have been developed by various organizations as to optimal rates. The American Hospital Association, for example, recommends medical-surgical occupancy of between 85% and 90%. Occupancy rates of 75% for pediatrics and from 70% to 75% for maternity services are sometimes used as guides by planners. But just as no single rate can be used to determine if an area has enough hospitals or enough beds, neither is there a single occupancy rate that will apply equally, for example, to urban and rural hospitals. The point is further discussed in the section on obstetrical beds.

The statewide occupancy for acute-care beds in all Missouri hospitals is 78.8%. Again, there are differences between the metropolitan and nonmetropolitan rates—81.0% compared to 71.9%. We can conclude there are disproportionately more general care beds in the metropolitan regions and they are more likely to be used. Individual hospital rates, of course, are much more varied than are the regional rates. Occupancy rates for the individual hospitals are shown in the detailed listing provided in the Appendix.

Another indication of utilization is discharges per 1,000 population. One cannot use these figures to represent the demand by residents of a region for hospital services. On the contrary, as will be seen, there is substantial crossing of regional boundaries. That is, extremely high rates of discharge can point to *de facto* medical centers—areas which draw people from surrounding areas. For example, the discharge rate in the Ozark Foothills region is 271.7 per 1,000 population. This is the highest in the state and is 5½ times the 49.4 rate for the Lake of the Ozarks region. It would be unrealistic to assume that residents of the two regions differ so greatly in their rates of hospitalization. One must conclude that residents of the Lake of the Ozarks region frequently go elsewhere to be hospitalized and that Ozark Foothills hospitals draw substantial numbers of people from other areas.

However, all the reasons for the 30% higher occupancy rate for metropolitan regions are not entirely clear. General hospitals in metropolitan areas tend to be much larger than those in nonmetropolitan areas; there is a correlation of .40 between hospital size and occupancy. From a series of hospital and health-need studies conducted by faculty and students at the University of Missouri-Columbia, Weil[11] concluded, and our findings agree, that the number of physicians in an area is a more significant variable affecting the number of occupied beds per 1,000 population than the number of beds available.

More physicians are located in metropolitan areas than in nonmetropolitan areas: the metropolitan rate of physicians to population is more than 80% higher than the nonmetropolitan rate[12] and physicians determine who is to be hospitalized and in which hospital. The correlation of .59 between the rate of physicians per 1,000 population and the rate of discharges per 1,000 population is higher than the correlation to hospital size. Weil found the availability of specialists particularly important, with higher rates of occupied beds in areas in which more specialists were located. As our study of physicians documented,[13] the higher rates of physicians in Missouri's metropolitan areas as compared to those in the nonmetropolitan areas are due entirely to the concentration of specialists in the former. Nonmetropolitan areas actually have a higher rate of general or family practitioners than metropolitan areas.

Hospital Utilization by Residents of Two Northwest Missouri Regions

Two northwestern Missouri Regional Planning Commission areas, Northwest Missouri and Mo-Kan Bi-State, were selected for this discussion which, we hope, will illustrate hospital utilization patterns within and between regions and even between states. Utilization data for this discussion were derived from voluntary reporting of hospital discharges to the Division of Health. All hospitals in these two regions participated in the program during 1971 as did all of the hospitals in adjacent Missouri counties. The number of discharges from this area reported to the Division of Health is known to be somewhat less than the actual total because northwestern Missouri residents used some hospitals in Kansas City which did not report discharge information to the Division of Health and because the extent of use of out-of-state hospitals also cannot be identified. We estimate, however, that 90% or more of the total hospitalizations to residents of these two regions are reported. (This estimate does not apply to individual counties and Worth County, in particular. Hospitalizations of Worth County residents are substantially underreported because of utilization of hospitals in Iowa.) In addition to this data source, we have made extensive use of a long-range plan completed in 1970 for the two large St. Joseph hospitals.[14]

The Mo-Kan Bi-State region contains a standard metropolitan statistical area as defined by the Census Bureau—St. Joseph and surrounding Buchanan County. The remaining counties in that region and all of the counties in the Northwest Missouri region are predominately rural. The population of these nine counties in 1970 was 168,375, with more than half located in St. Joseph and Buchanan County.

Table 6 shows the rates of hospital utilization for each 1,000 residents in these nine counties. Examination of the age distribution for this area shows that the older age groups account for a larger percentage of the total population than for Missouri as a whole. Excluding Nodaway County, which contains a state university and, therefore, a substantial number of young people, the percent of the population age of 65 and older ranges from 14.8% in Buchanan County to 23.1% in Gentry County. This compares with 12.9% for Missouri and 9.9% for the

TABLE 6

TOTAL POPULATION, POPULATION 65 AND OVER AND REPORTED HOSPITALIZATIONS TO RESIDENTS OF A NINE-COUNTY NORTHWESTERN MISSOURI AREA

Place of Residence	*Population (1970)*	*Number 65 & Over (1970)*	*Population (1971 est)*	*Number Hospitalized (1971)*	*Percent of Population 65 & Over*	*Rate Hospitalized Per 1,000 Population*
Mo-Kan Bi-State						
Buchanan	86,915	12,866	87,400	15,741	14.8	180.1
Clinton	12,462	2,130	12,900	2,029	17.1	157.3
Andrew	11,913	1,872	12,400	1,596	15.7	128.7
DeKalb	7,305	1,462	7,500	1,170	20.0	156.0
Region total	118,595	18,330	120,200	20,536	15.5	170.8
Northwest Missouri						
Nodaway	22,467	3,284	22,700	4,034	14.6	177.7
Atchison	9,240	1,459	9,600	1,599	15.8	166.6
Gentry	8,060	1,865	8,300	1,243	23.1	149.8
Holt	6,654	1,405	6,600	1,093	21.1	165.6
Worth	3,359	720	3,400	312	21.4	91.8
Region total	49,780	8,733	50,600	8,281	17.5	163.7
Nine-county total	168,375	27,063	170,800	28,817	16.1	168.7

United States. For the area as a whole, 16.1% of the population is 65 or over. People in these older age groups are more likely to be hospitalized and tend to remain hospitalized longer than those in younger age groups. In the United States, the number of discharges in 1971 for each 1,000 people of age 65 and over was 305.7; for persons under age 15, the comparable number was only 70.2. Equally significant was the average length of stay of 4.7 days for patients under age 15 compared to 12.8 days for those 65 and over.[15] Expressed another way, people 65 years old and over are nearly 4½ times as likely to be hospitalized as those under 15 years old. When they are hospitalized, they are likely to stay more than 2½ times as long.

One would expect higher rates of hospitalization in those counties with the largest percentage of aged. According to our data, approximately one out of every six persons from these nine counties is hospitalized in the course of a year and, as would be expected, hospitalization of residents of the region is more frequent than the one in seven for the United States general population. Review by individual counties, however, does not fully support this expectation.

Buchanan County residents, for example, have the highest hospitalization rate in the area, although the percentage of population of age 65 and over is distinctly lower than for most of the other counties in the area. Atchison and Holt counties differ considerably in the percentage of aged in the population; Atchison County's population includes 15.7% of age 65 and over compared to 21.1% for Holt County. The hospitalization rates for residents of these two counties, however, are essentially the same—166.6 per 1,000 population for Atchison County as compared to 165.5 for Holt County. Atchison County contains a hospital; Holt County does not. Thus, the proximity of a hospital influences the hospitalization rate as well as the percent of aged in the population.

The detailed analysis for the area also clarifies some of the metropolitan region rural data reported above. Even though smaller local hospitals are more accessible in terms of distance, there is extensive use of larger metropolitan area hospitals as shown in Table 7. Practically all residents of the five counties of the Northwest Missouri region are closer to hospitals in Atchison, Nodaway or Gentry counties than to the hospitals located in St. Joseph. Yet, of the reported hospitalizations from those five rural counties, almost one in five (17.5%) were hospitalized in St. Joseph and an additional 1.3% were hospitalized in Kansas City.

As would be expected, distance from the metropolitan hospitals has a significant effect. Of the reported hospitalizations of residents of Atchison County, most distant from St. Joseph, 91.1% were in the local hospital and only 4.2% in St. Joseph. In contrast, of the reported hospitalizations

TABLE 7

COUNTY OF HOSPITALIZATION FOR RESIDENTS OF A NINE-COUNTY NORTHWESTERN MISSOURI AREA 1971

Place of Residence	*Place of Hospitalization*						Subtotal	Kansas City	Rest of State	Grand Total
	BUCHANAN	NODAWAY	ATCHISON	CLINTON	GENTRY	HARRISON				
Mo-Kan Bi-State										
Buchanan	15,443	15	14	12	6	4	15,494	140	107	15,741
Clinton	677	1	1	829	0	5	1,513	63	453	2,029
Andrew	1,485	64	12	3	5	1	1,570	12	14	1,596
DeKalb	637	15	1	426	9	10	1,098	29	43	1,170
Region total	18,242	95	28	1,270	20	20	19,675	244	617	20,536
Northwest Missouri										
Nodaway	403	3,409	116	0	43	1	3,972	34	28	4,034
Atchison	67	31	1,456	0	0	0	1,554	29	16	1,599
Gentry	354	66	0	8	733	31	1,192	15	36	1,243
Holt	563	28	442	3	3	0	1,039	22	32	1,093
Worth	65	54	0	1	162	4	286	11	15	312
Region total	1,452	3,588	2,014	12	941	36	8,043	111	127	8,281
Nine-county total	19,694	3,683	2,042	1,282	961	56	27,718	355	744	28,817

to residents of Clinton County which is adjacent to St. Joseph, only 40.9% were in the hospital located within Clinton County. Almost as many of the hospitalizations of Clinton County residents (33.4%) were in Buchanan County and a minimum (3.1%) were in Kansas City. Not surprisingly, residents of Buchanan County utilized St. Joseph hospitals almost exclusively with only 0.9% being hospitalized in Kansas City.

The use of the local "rural" hospital versus a metropolitan health center hospital also can be better understood by comparing births and deaths. Although hospitalizations of Missouri residents are not now completely reported to the Division of Health, births and deaths are reported and use of these records gives the advantage of complete reporting. Detailed examination of these records for residents of the nine-county area provides additional insight into patterns of hospital utilization, particularly since approximately 99% of all births now occur in hospitals.

It is clear in Table 8 that a relatively large number of hospital deaths, as compared to hospital births, occur at a considerable distance from the place of residence. This would indicate that people with serious illnesses are likely to select hospitals on some basis other than geographic accessibility. For example, Nodaway County residents are certainly closer to St. Joseph than to Kansas City, yet more Nodaway County residents died in Kansas City hospitals than in St. Joseph hospitals. This also was true for Atchison County residents. Interestingly, more residents of Atchison County died in hospitals in Omaha, Neb. than in Kansas City and St. Joseph combined; this indicates use of Omaha as a regional medical center for residents of this far northwest corner of Missouri. Overall, for all of Northwest Missouri, 12.7% of the hospital deaths occurred in hospitals two or more counties distant from the place of residence.

On the other hand, births generally occur closer to home. For the nine-county area, 95.2% of the hospital births occurred either in the mother's county of residence or in the adjacent county. Less than 5% of the births occurred in more distant hospitals.

Crossing of state lines for hospital services is common, especially for residents of border counties not having their own hospitals. Worth County provides the best example; nearly one third of the hospital deaths and almost one half of the hospital births occurred in Iowa hospitals in 1972.

The Worth County figures illustrate another factor which should be considered. Since a hospital service area is generally defined as that area from which a hospital draws the majority of its patients, the importance of a particular hospital to residents of a small county could be easily overlooked. The St. Joseph study points out this possibility with regard to Worth County, which contains less than

TABLE 8

DISTANCE OF HOSPITALIZATION FROM PLACE OF RESIDENCE, BIRTHS AS COMPARED TO DEATHS FOR RESIDENTS OF A NINE-COUNTY NORTHWESTERN MISSOURI AREA
1972

	Number Hospitalized						*Percent Hospitalized*			
	IN OWN OR ADJACENT COUNTY		TWO OR MORE COUNTIES DISTANT		*Total Hospitalized*		IN OWN OR ADJACENT COUNTY		TWO OR MORE COUNTIES DISTAN	
Place of Residence	BIRTHS	DEATHS	BIRTHS	DEATHS	BIRTHS	DEATHS	BIRTHS	DEATHS	BIRTHS	DEATH
Mo-Kan Bi-State										
Buchanan	1,288	675	30	80	1,318	755	97.7	89.4	2.3	10.6
Clinton	185	86	13	6	198	92	93.4	93.5	6.6	6.5
Andrew	144	56	2	5	146	61	98.6	91.8	1.4	8.2
DeKalb	87	49	9	9	96	58	90.6	84.5	9.4	15.5
Region total	1,704	866	54	100	1,758	966	96.9	89.6	3.1	10.4
Northwest Missouri										
Nodaway	252	170	33	33	285	203	88.4	83.7	11.6	16.3
Atchison	120	74	4	15	124	89	96.8	83.1	3.2	16.9
Gentry	74	55	21	20	95	75	77.9	73.3	22.1	26.7
Holt	88	65	0	11	88	76	100.0	85.5	0.0	14.5
Worth	28	34	2	5	30	39	93.3	87.2	6.7	12.8
Region total	562	398	60	84	622	482	90.4	82.6	9.6	17.4
Nine-county total	2,266	1,264	114	184	2,380	1,448	95.2	87.3	4.8	12.7

4,000 people. In terms of the number of patients from 12 counties admitted to the two large St. Joseph hospitals, Worth County ranked last with 48 admissions. This was only 0.2% of the total admissions to these two hospitals. These same 48 admissions, however, represented 16% of all (Missouri) hospital admissions for Worth County residents. Considering the percentage of population of each of these 12 counties seeking care in St. Joseph, Worth County ranked sixth. Obviously, the availability of medical service in the St. Joseph hospitals is of different (and much greater) importance to Worth County residents than to the hospital administrators.

Another important concept related to hospital service areas is that different service areas may exist for different services provided by the same hospital. That is, the service area for general medical and surgical care or for obstetrical care is quite different from the service area for cobalt therapy, open-heart surgery or other advanced procedures. Planners should be cognizant of this. The purpose of delineating a service area is to enable the decision-makers, the planners, to establish priorities. Planners must first define the service to be provided and then determine the service area.

SPECIALIZATION OF HOSPITALS IN MISSOURI

All hospitals do not provide the same services. Just as physicians specialize, so hospitals also have tended to specialize. There are mental hospitals, pediatric hospitals and other such hospitals oriented toward specific subgroups of the total population. The analogy of specialization of hospitals to specialization of physicians is not perfect; hospital specialization is rarely as complete as physician specialization. Most larger "general" hospitals offer a broad range of services.

Differences are evident in the distribution of beds provided for different types of care and in the utilization patterns of these beds. In this section, we will examine these patterns as they relate to broad hospital specialization.

Medical-Surgical Care

Hospital administrators and analysts generally subdivide hospital services into medical-surgical, obstetric, pediatric, psychiatric and long-term care. The first three of these have developed historically as functions of "general" hospitals. It is the beds devoted to all of these services that we refer to in this report as "general care" beds.

Nearly 85% of the hospital beds in the general care category are provided for medical-surgical care. Beds in this service tend to have higher occupancy rates than beds in pediatric or obstetric services, which are discussed separately following this sec-ion. Loosely translated, medical-surgical beds are rimarily for the general adult population in need f hospital care because of physical illness or inury. In this sense, these are beds for adults as peditric-hospital beds are beds for children. (At times, articularly in smaller hospitals without separate ediatric units, some of these beds will be occupied y children, but the number of beds used by chilren is small.) In 1971, 153 of Missouri's hospitals rovided medical-surgical services. This was 88.4% f all hospitals and 96.8% of hospitals providing eneral care services.

Distribution of medical-surgical beds throughout Missouri parallels fairly closely the distribution of he adult population as shown in Table 9. A comarative look at the average annual occupancy rates or medical-surgical beds in the 20 regions shows gain that differences in utilization are substantial. The occupancy rate of medical-surgical beds in metropolitan regions is higher than in nonmetropolitan regions—82.0% compared to 76.9%.

The average occupancy rate was 80.7% for medical-surgical beds in Missouri for 1971. By region, they ranged from a low of 64.2% to a high of 86.1%. There were only four regions (East-West Gateway, Lakes Country, Mo-Kan Bi-State and Ozark Gateway) in which these beds were being operated at or above the level of 85% which the American Hospital Association considers a minimum from the standpoint of efficient utilization. All were high population areas.

We have previously discussed some of the factors related to occupancy and utilization, such as hospital size and the number and specialties of physicians in the immediate area. That discussion showed that people with serious, life-threatening illnesses

TABLE 9
MEDICAL-SURGICAL FACILITIES IN ALL HOSPITALS BY REGIONAL PLANNING COMMISSION AREAS
MISSOURI, 1971

Geographic Area	*Population Age 20 and Over (1970)*	*Hospitals with Med-Surg Services*	*Number of Med-Surg Beds*	*Average Daily Census*	*Percent of Adult Population*	*Percent of Med-Surg Beds*	*Percent of Average Daily Census*	*Occupancy Rate*
Metropolitan Regions								
East-West Gateway	1,127,028	29	7,633	6,491.0	38.1	40.0	39.2	85.0
Mid-America	545,477	24	3,622	2,987.3	18.5	19.0	18.9	82.5
Lakes Country	185,657	11	1,497	1,279.7	6.3	7.8	8.1	85.5
Mid-Missouri	141,694	10	1,398	1,118.2	4.8	7.3	7.1	80.0
Mo-Kan Bi-State	76,939	4	542	466.9	2.6	2.8	3.0	86.1
Nonmetropolitan Regions								
Northwest Missouri	33,271	3	182	142.0	1.1	1.0	0.9	78.0
Green Hills	60,674	8	357	278.8	2.1	1.9	1.8	78.1
Missouri Valley	32,618	3	198	128.8	1.1	1.0	0.8	65.1
Northeast Missouri	31,048	4	256	164.3	1.1	1.3	1.0	64.2
Mark Twain	78,908	6	427	305.4	2.7	2.2	1.9	71.5
Boonslick	24,685	1	68	44.0	0.8	0.4	0.3	64.7
Ozark Gateway	88,788	8	631	538.3	3.0	3.3	3.4	85.3
Kaysinger Basin	58,354	8	331	266.6	2.0	1.7	1.7	80.5
Show-Me	60,870	4	310	252.7	2.1	1.6	1.6	81.5
South Central Ozark	57,103	4	152	104.6	1.9	0.8	0.7	68.8
Meramec	56,752	5	238	198.0	1.9	1.2	1.3	83.2
Lake of the Ozarks	70,492	2	133	90.1	2.4	0.7	0.6	67.7
Southeast Missouri	88,917	9	694	534.8	3.0	3.6	3.4	77.1
Bootheel	97,230	6	490	372.3	3.3	2.6	2.4	76.0
Ozark Foothills	39,919	4	392	313.8	1.4	2.1	2.0	80.1
Totals								
Metropolitan total	2,076,795	78	14,692	12,043.1	70.2	74.6	76.3	82.0
Nonmetropolitan total	879,629	75	4,859	3,734.5	29.8	25.4	23.7	76.9
Missouri total	2,956,424	153	19,551	15,777.6	100.0	100.0	100.0	80.7

are frequently referred to specialists for treatment and subsequent hospitalization or, sometimes, if hospitalized locally, they are referred elsewhere. Thus, some of the largest metropolitan hospitals serve as referral hospitals in addition to serving some metropolitan region residents as primary places of hospitalization.

Today's advanced medical and surgical procedures are increasingly able to extend useful life. Frequently, however, these require extended or repeated hospitalizations. Kidney dialysis is but one example of such procedures. As these and other techniques become more universally available, the demand for medical-surgical beds might be expected to increase. As was pointed out in the St. Joseph study, "The only relatively stable aspect of changing patterns of medical care in the United States has been a steadily-increasing reliance on the part of patients and physicians on the hospital rather than the home or the physician's office as the focal point for the provision of most medical care services, whether it be for acute, extended, or chronic care or diagnostic services."[16]

It could be argued, of course, that as techniques improve both in medicine and surgery, as new drug discoveries occur and, perhaps, as more "surgicenter" types of facilities are established or as insurance coverage becomes more available for outpatient care, admission rates might decline. The long-term trend, however, has been ever-increasing admission rates, and it seems reasonable to expect that any reversal of this trend will require substantial changes in the delivery of health care services.

Increases or decreases in use of hospital beds are dependent upon medical advances. One example is today's decreased need for tuberculosis beds. As recently as 1960, seven Missouri hospitals listed beds specifically for tuberculosis patients. These included the 250-bed Kansas City Tuberculosis Hospital and a 250-bed Veterans Administration hospital in Excelsior Springs operated exclusively for tuberculosis patients. Both of these facilities have since closed. In 1960, the Missouri State Sanatorium contained 625 beds, all for tuberculosis patients. By 1971, the renamed Missouri State Chest Hospital contained only 300 tuberculosis beds; an additional 159 beds in that facility are now used for patients with other chest and pulmonary diseases.

This illustrates another area of concern for planners and that is flexibility. As Mann points out, "Highly specialized tuberculosis hospitals were built at a great expense in the first half of the 20th century. After the introduction of isoniazid and streptomycin in the late 1940s, the TB death ra dropped by 95%. Thus, hospital uses were drama cally changed in a very short time."[17] A potential r sult of such changes, of course, is obsolescenc Medical advances are not entirely predictable, b examination of alternative uses for present and pr posed facilities should be part of the planning pr cess.

Maternity Care

Like the nation as a whole, Missouri has bee experiencing marked changes in regard to bir rates. During 1971, the nation's birth rate reached 31-year low. Missouri's rate has experienced a sim lar decline. This decline, combined with an earli trend to a shorter average length of stay for ob stetric patients, has resulted in a major decline i need for obstetric beds. Within the past decade, number of hospitals have discontinued maternit services. In 1971, only 125 Missouri hospitals (79.1% of all general hospitals) reported maternit services compared with more than 90% in 1960. I addition, occupancy levels for the beds provide for this service has declined. For the state as whole, the occupancy rate for obstetric beds 56.4% compared to the rate of 81.8% for medica surgical beds.

The effects of these trends are clearly demon strated in Table 10. Comparing the 20 regions, th average occupancy rate varied from a low of 25.6 for the one hospital in a rural region to a high c only 69.8% for the 22 hospitals in the largest metro politan area, East-West Gateway. Utilization is ger erally higher in the metropolitan areas; on an aver age day, 64.4% of the maternity beds in the metro politan regions are filled. This is nearly double th 36.6% level in the nonmetropolitan regions.

It is generally agreed that it is uneconomical t maintain beds and services when they are utilize only 56.4% of capacity. Planners frequently use oc cupancy rates of between 70% and 75% as a desira ble level of utilization for obstetrical units. Th American College of Obstetricians and Gynecolo gists has set standards for obstetrics service and ha stated that in order to maintain minimum levels o staff expertise, an inpatient program should aver age 1,500 or more deliveries annually. Using th average length of stay of 4.0 days for obstetrica conditions, 1,500 deliveries a year would provid an occupancy rate of 74.7% for a 22-bed maternit unit.

These and similar guidelines cannot be used a the sole criteria for measuring need for obstetrica

TABLE 10

OBSTETRIC FACILITIES IN ALL HOSPITALS BY REGIONAL PLANNING COMMISSION AREAS
MISSOURI, 1971

eographic Area	*Number of Resident Live Births*	*Hospitals with Obstetric Services*	*Number of Obstetric Beds*	*Average Daily Census*	*Percent of Resident Live Births*	*Percent of Obstetric Beds*	*Percent of Average Daily Census*	*Occupancy Rate*
etropolitan Regions								
ast-West Gateway	31,154	22	664	463.4	39.7	37.4	46.2	69.8
id-America	15,624	19	361	221.1	19.9	20.3	22.0	61.2
akes Country	4,847	6	95	55.7	6.2	5.4	5.5	58.6
id-Missouri	3,615	8	108	55.1	4.6	6.1	5.5	51.0
o-Kan Bi-State	1,892	4	44	24.5	2.4	2.5	2.4	55.7
onmetropolitan Reigons								
orthwest Missouri	708	3	25	7.6	0.9	1.4	0.8	30.4
reen Hills	1,186	7	35	10.3	1.5	2.0	1.0	29.4
issouri Valley	664	3	13	4.3	0.8	0.7	0.4	33.1
ortheast Missouri	769	4	27	7.7	1.0	1.5	0.8	28.5
ark Twain	1,734	6	54	17.6	2.2	3.0	1.8	32.6
oonslick	601	1	10	2.6	0.8	0.6	0.3	25.6
zark Gateway	2,203	8	78	25.2	2.8	4.4	2.5	32.3
aysinger Basin	1,143	6	40	10.6	1.5	2.3	1.1	26.5
how-Me	1,554	4	31	14.7	2.0	1.7	1.5	47.4
outh Central Ozark	1,377	4	22	8.1	1.8	1.2	0.8	36.8
eramec	1,579	3	16	9.9	2.0	0.9	1.0	61.9
ake of the Ozarks	1,345	1	12	3.4	1.7	0.7	0.3	28.7
outheast Missouri	2,284	8	62	32.2	2.9	3.5	3.2	51.9
ootheel	3,072	5	49	20.3	3.9	2.8	2.0	41.4
zark Foothills	1,024	3	28	9.4	1.3	1.6	0.9	33.6
otals								
etropolitan total	57,132	59	1,272	819.8	72.9	71.7	81.7	64.4
onmetropolitan total	21,243	66	502	183.9	27.1	28.3	18.3	36.6
issouri total	78,375	125	1,774	1,003.7	100.0	100.0	100.0	56.4

nd newborn services. Noteworthy is that nine of issouri's 20 regions had fewer than 1,500 resi-lent live births in 1971 and four had fewer than ,000. Obstetrical services must be available to serve ommunity needs. Because of distance, it is not easible to use "excess" beds in one geographic area o offset unmet needs in another area. In addition, imitations imposed by professional standards and icensing regulations preclude the use of excess naternity beds and delivery rooms for other types f care. These problems have been met in some ommunities in which several hospitals in the same mmediate area offering obstetric care have con-olidated maternity services.

It is clear from the statewide occupancy rate and rom rates for obstetric units in individual hospitals hat the mere presence of a maternity service does ot mean it will be utilized. Selection of facilities for maternity services is somewhat unique in that there is ample forewarning of the need for hospitalization. In approximately 90% of the live births for 1972, for example, prenatal care began in the first or second trimester of pregnancy. The pregnant woman has time to select her physician, and the physician has time to select the hospital if he is on more than one staff. For planning of maternity services, it is important to know which physicians are performing the deliveries and which hospitals they prefer to utilize.

Pediatric Care

Distribution and utilization patterns of pediatric services contrast sharply with those of the other components of general care. Pediatric services are much more highly concentrated in certain regions and, even more importantly, in particular hospitals

TABLE 11

DEATHS FROM SELECTED DISEASES BY SELECTED AGE GROUP MISSOURI, 1930 AND 1970

Cause of Death	*Under 1 Year 1930*	*1-4 Years 1930*	*5-9 Years 1930*	*10-19 Years 1930*	*19 Years and Under 1930*	*1970*
Whooping cough	74	41	6	1	122	0
Diphtheria	11	93	42	8	154	0
Measles	17	40	16	10	83	0
Scarlet fever	4	32	21	14	71	0
Typhoid	2	15	24	73	114	0
Tuberculosis	28	50	36	185	299	0
Total of above	136	271	145	291	843	0

within those regions. Two factors have accounted for this.

The first factor has been the virtual eradication of many communicable diseases. We tend to forget how many children died from diseases which are considered rare occurrences today. A few examples from 1930 illustrate this as listed in Table 11. There are, of course, other serious pediatric illnesses. It is evident, however, that early immunization, use of new drugs and improved sanitation have almost eliminated deaths from many of the formerly common communicable diseases. Historically, many communities provided specialized hospitals or distinct units of general hospitals for infectious diseases. As the incidence of these diseases in children diminished, however, so did the utilization of these units decrease. The last important group of patients these served were those with poliomyelitis before the advent of the Salk and Sabin vaccines. The threat of serious and potentially fatal illness in children has certainly been reduced. As a result of the lessened demand, many hospitals have closed or reduced in size their pediatric facilities. Today, fewer than half of Missouri's general hospitals report a distinct service unit exclusively for pediatric patients.

The second factor has been the development of intensive neonatal care facilities. Very low birthweight infants need a different type of care than do full-term babies. Surgical procedures are being performed at earlier ages as new techniques are perfected. These and other types of highly specialized pediatric care require sophisticated and expensive equipment and, also, highly skilled staff. Such advances in treatment capabilities have encouraged the concentration of pediatric services in facilities specializing in pediatric care. Reflecting the benefits resulting from this specialized care is the substantial decrease in the risk of death in the early stages of life. In 1930, 859 infants died within 24 hours of birth, a rate of 13.9 deaths for each 1,000 live births. In 1972, despite a larger number of births, the number of deaths within the first day of birth had been reduced to 534 for a rate of 7.4. Improvement in the over-one-day-under-one-month age group was even more marked: a rate of 19.2 deaths in 1930 compared to only 6.2 in 1972.

Thus it is clear that many of the medical advances in prevention and management of illness made in the last half century or so have been of particular benefit to children. These advances have led simultaneously to a reduced number of beds and to a high concentration of pediatric services and utilization of those services within particular regions. As shown in Table 12, metropolitan regions contain only 72.3% of the population of age 19 and under, but hospitals within these regions contain 87.5% of the pediatric bed complement. Figures on the average daily census show an even higher concentration. Of the total number hospitalized in pediatric units on the average day, 90.7% were in the metropolitan regions.

Since Missouri contains several hospitals which serve only pediatric patients, it is to be expected that pediatric services would be concentrated within these facilities. The extent of this concentration, however, may be surprising. Two general pediatric hospitals and one orthopedic hospital for children are located in the St. Louis region; another general pediatric hospital is located in the Kansas City region. The average daily census for just these four hospitals (of 173 in Missouri) represented 43.3% of the total reported for pediatrics for the entire state.

The implication for planners of this existing concentration and regionalization of pediatric services is obvious. It would be questionable to establish new pediatric facilities in an area close to well-established, highly specialized facilities. If no such sophisticated facility exists in an area, upgrading an already existing facility and arranging for referral might be preferable to adding still another small unit.

Psychiatric Care

Facilities for treating mental diseases developed separately from general hospital care. While most general hospitals were developed and supported locally, most mental hospitals were operated by the

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Donnagel with paregoric equivalent
Each 30 cc. contains:

Kaolin	6.0 g
Pectin	142.8 mg
Hyoscyamine sulfate	0.1037 mg
Atropine sulfate	0.0194 mg
Hyoscine hydrobromide	0.0065 mg
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg
Sodium benzoate (preservative)	60.0 mg
Alcohol, 5%	

Ⓒ Available on oral prescription or without prescription in compliance with applicable state and local law

4 FL OZ
Robitussin
EXPECTORANT
KEEP THIS AND ALL MEDICINES OUT OF REACH OF CHILDREN
Robitussin A-C
Robitussin DM
Robitussin-PE
Robitussin-CF
Cough Calmer
Cough Suppressant Lozenges

A·H·ROBINS

IN COUGHS OF COLDS, FLU, AND U.R.I.: CLEAR THE TRACT WITH THE ROBITUSSIN® LINE

Fall and winter coughs are back. Time to help clear the lower respiratory tract with the five Robitussins and Cough Calmers. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

For unproductive coughs

ROBITUSSIN®

Each 5 cc. contains:

Glyceryl guaiacolate .... 100 mg.

Alcohol, 3.5%

For severe coughs

ROBITUSSIN A-C®Ⓒ

Each 5 cc. contains:

Glyceryl guaiacolate .... 100 mg.

Codeine phosphate .... 10.0 mg.

(warning: may be habit forming)

Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

ROBITUSSIN-DM®

Each 5 cc. contains:

Glyceryl guaiacolate .... 100 mg.

Dextromethorphan hydrobromide .... 15 mg.

Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS®

Each Cough Calmer contains:

Glyceryl guaiacolate .... 50 mg.

Dextromethorphan hydrobromide .... 7.5 mg.

Clears nasal and sinus passages as it relieves coughs

ROBITUSSIN-PE®

Each 5 cc. contains:

Glyceryl guaiacolate .... 100 mg.

Phenylephrine hydrochloride .... 10 mg.

Alcohol, 1.4%

MEET THE NEWEST MEMBER OF THE LINE

Comprehensive decongestant action helps control cough and clear stuffy nose and sinuses. Non-narcotic.

ROBITUSSIN®-CF

Each 5 cc. contains:

Glyceryl guaiacolate .... 50 mg.

Dextromethorphan hydrobromide .... 10.0 mg.

Phenylpropanolamine hydrochloride .... 12.5 mg.

Alcohol, 1.4%

Select the Robitussin® formulation that treats your patient's individual coughing needs:	Expectorant-Demulcent	Cough Suppressant	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
ROBITUSSIN®	●				●
ROBITUSSIN A-C®	●	●			
ROBITUSSIN-DM®	●	●	●		●
ROBITUSSIN-PE®	●			●	●
ROBITUSSIN®-CF	●	●		●	●
COUGH CALMERS®	■	■	■		■

A. H. Robins Company, Richmond, Va. 23220

TABLE 12

PEDIATRIC FACILITIES IN ALL HOSPITALS BY REGIONAL PLANNING COMMISSION AREAS MISSOURI, 1971

Geographic Area	*Population Age 19 and Under (1970)*	*Hospitals with Pediatric Services*	*Number of Pediatric Beds*	*Average Daily Census*	*Percent of Population 19 and Under*	*Percent of Pediatric Beds*	*Percent of Average Daily Census*	*Occupanc Rate*
Metropolitan Regions								
East-West Gateway	699,879	20	854	610.8	40.7	50.4	55.9	71.5
Mid-America	321,531	14	393	225.3	18.7	23.2	20.6	57.3
Lakes Country	97,403	4	92	41.4	5.7	5.4	3.8	44.7
Mid-Missouri	83,686	7	107	54.2	4.9	6.3	5.0	50.7
Mo-Kan Bi-State	41,656	3	38	27.6	2.4	2.2	2.5	72.6
Nonmetropolitan Regions								
Northwest Missouri	16,509	1	2	0.8	1.0	0.1	0.1	40.0
Green Hills	27,064	2	4	1.9	1.6	0.2	0.2	47.5
Missouri Valley	15,664	—	—	—	0.9	—	—	—
Northeast Missouri	15,540	2	22	9.6	0.9	1.3	0.9	43.6
Mark Twain	40,212	2	37	16.8	2.3	2.2	1.5	45.4
Boonslick	14,055	1	6	1.4	0.8	0.4	0.1	24.2
Ozark Gateway	46,753	5	51	21.1	2.7	3.0	1.9	41.4
Kaysinger Basin	25,897	1	4	3.2	1.5	0.2	0.3	80.9
Show-Me	34,065	1	7	4.9	2.0	0.4	0.4	70.3
South Central Ozark	30,275	1	2	0.7	1.8	0.1	0.1	35.0
Meramec	32,829	3	14	9.0	1.9	0.8	0.8	64.3
Lake of the Ozarks	41,642	1	3	1.7	2.4	0.2	0.2	56.5
Southeast Missouri	51,501	2	19	8.0	3.0	1.1	0.7	42.1
Bootheel	61,973	1	8	4.8	3.6	0.5	0.4	59.9
Ozark Foothills	21,943	2	33	17.8	1.3	1.9	1.6	53.9
Totals								
Metropolitan total	1,244,155	48	1,484	990.4	72.3	87.5	90.7	66.7
Nonmetropolitan total	475,922	25	212	101.7	27.7	12.5	9.3	48.0
Missouri total	1,720,077	73	1,696	1,092.1	100.0	100.0	100.0	64.4

government. Despite the fact that some general hospitals include psychiatric units, this situation persists. Of the 8,719 psychiatric care beds identified in Missouri for 1971, 7,690 (88.2%) are under the control of the State Division of Mental Health.

The five state mental hospitals, which began operations in the period of 1851-1903, are geographically dispersed throughout Missouri. Each serves a predefined geographic area. More recently, three psychiatric rapid-treatment facilities also have been established under the auspices of the Division of Mental Health.

The concept of dealing with mental illness has changed radically in recent years. Whereas not so many years ago mental hospitals were primarily custodial institutions, the emphasis today is on treatment and release back to the community and on treatment within the community. To this end, "traveling" and outpatient clinics are operated by the hospitals.

Because inpatient facilities for treating mental illness generally serve a much larger geographic area than do facilities for treating physical illness and because of the increasing emphasis on outpatient treatment, a discussion of inpatient facilities by region would not accurately describe the availability of psychiatric care. The detailed hospital listing in the Appendix, however, does show beds identified by the hospitals for psychiatric patients.

Long-Term Care

Yet another service offered by some hospitals is long-term care, sometimes termed extended care. Generally, beds in this category serve convalescent patients who no longer require intensive medical supervision, but are not yet able to function independently at home.

Long-term care services provided by hospitals are similar to the services provided by nursing homes and will be discussed in a future report in this series. Again, however, the Appendix lists long-term care beds in Missouri's hospitals.

Summary

Costs of hospital care have risen sharply in recent years. As a result, hospital planning has become increasingly important. The need for effective planning is two-fold: to ensure availability of needed hospital services while simultaneously avoiding expensive duplication. In 1971, there were approximately 20,000 general care beds in Missouri and approximately 18,150 were filled on an average day. Approximately 21% or about 4,870 beds were empty.

This report has demonstrated that the location and use of hospital facilities in Missouri is influenced by many different factors. No single formula or no simple formula will provide a plan or identify the optimum number of beds or mix of services for a community.

Occupancy rates of existing facilities provide a measure of present utilization, but present population structure and predicted population change in the next several decades must be considered. Planners in areas which are medical centers must consider not only the needs of residents of the immediate area, but also the needs of more distant populations which are referred to the medical centers for the more unusual or uncommon medical problems.

All of these and other factors must then be brought into perspective and related to the legislated social, fiscal and regulatory programs increasingly being imposed by government. In 1974, as this paper is being written, hospital planners almost require an explanatory handbook to identify the various agencies and acronyms for CHP, HMO, COLC, NHI, PSRO and other governmental and private associations involved in hospital planning, regulation and operation.

Whatever the agency and no matter what the regulations, hospitals will continue as essential, visible elements of health services. Medical science today requires the concentration of a large team of highly trained individuals and sophisticated and expensive equipment brought together with the patient in the physical structure called the hospital.

Hospitals have developed and will continue to develop and change in response to the health needs of the population served and the medical science resources to meet patient needs. The major changes in hospitals in the past several decades have developed primarily because of medical advances; hospital operation and regulation must be responsive to these advances and, more importantly, to the needs of the patient.

Many of the elements that must be considered in hospital planning have been identified. Some of these can be put into statistical terms. Not all can be, however, for there are more, and often more potent, motors of individual and group behavior than those which can be demonstrated in a statistical table.

Planning must begin with an evaluation of how well current resources meet the needs for health facilities. Those in decision-making positions must then take action based on best estimates as to the projected population of the area to be served, the effect of yet-unknown medical advances and the effect of governmental or other outside influences on the delivery of health services to predict future facility needs.

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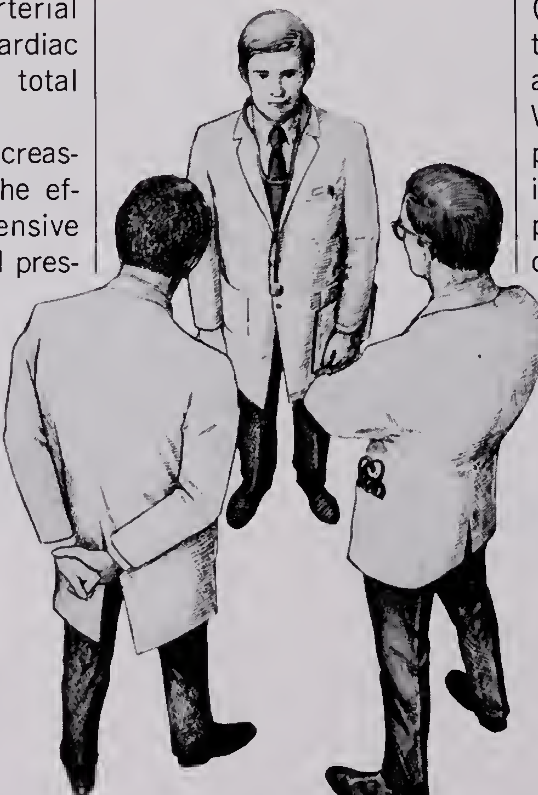
The more physicians consider the hemodynamics o lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

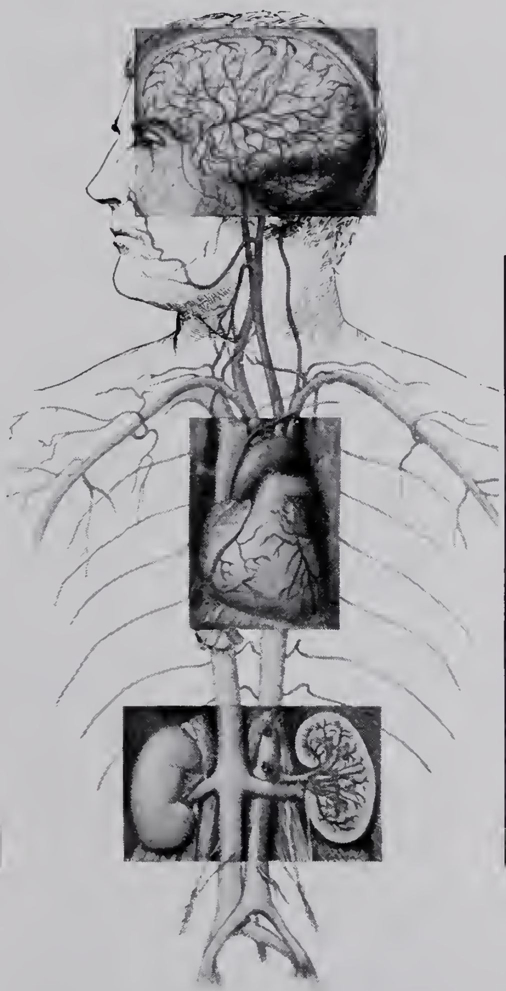
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

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In most cases of sustained moderate hypertension

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smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

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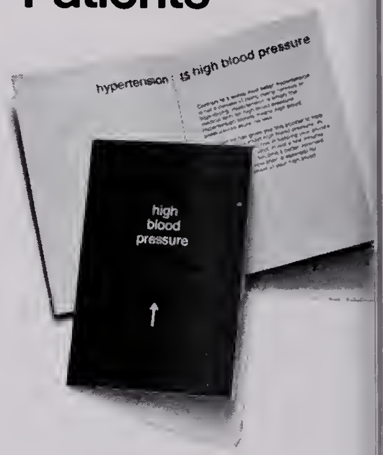
"Required Reading" For Your Hypertensive Patients



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WASHINGTON

The Senate has overwhelmingly passed legislation that would require one fourth of all medical and dental school graduates to spend at least two years in the nation's slums and rural areas where there are shortages of physicians.

Earlier the Senate voted down a much more sweeping bill sponsored by Sen. Edward Kennedy that would have required mandatory federal service for all health professions students and national licensure and relicensure for physicians and dentists.

Hours before the first Senate vote, Senator Kennedy, aware that he was losing liberal support, shelved his Health Subcommittee's $5.1 billion, five-year bill and offered a substitute measure which was trounced 57-34. Instead, the Senate adopted a measure sponsored by Sen. J. Glenn Beall, Jr. (R-Md.) and went on to pass a three-year, $2 billion health manpower bill by a vote of 81-7.

The bill, which was finally approved by the Senate, was stripped of most of the controversial provisions of the original Kennedy bill and was a victory for the American Medical Association, the American Dental Association and the Association of American Medical Colleges.

The Senate bill calls for a three-year extension of present federal programs for aiding medical education at a total cost of about $2 billion. Capitation grants for medical schools would be continued at a high level despite the administration's request for a cutback.

The Beall substitute measure provides federal aid to medical and dental schools that agree to allocate 25% of their classroom space to students volunteering to serve in areas short of medical care workers. In return for either civilian or federal service under the National Health Service Corps, the students would receive scholarships.

The Kennedy bill would have compelled all medical school graduates to serve in the shortage areas, an approach labelled a "domestic draft" by Senator Beall and his committee colleagues Senators Peter Dominick (R-Colo.), and Robert Taft, Jr. (R-Ohio), who developed the substitute measure.

The Senate bill does not contain the original requirement for a federally-appointed National Council on Postgraduate Education with ten regional councils designed to deal with allocation of speciality training slots and foreign medical graduates. The Senators contended this was too heavy an involvement of the federal government.

Another casualty of the Senate voting was the proposal for federal standards for licensing and relicensing physicians and dentists, a plan that stirred wide protest within the professions.

The Maryland Senator's bill represented a middle ground on financial help for medical schools, with the AAMC contending the amount was too low and the Administration believing it was too high.

Immigration standards would be tightened to restrict the number of foreign medical graduates under the Senate bill.

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When diarrhea wrings the wedding belle...

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X-ray studies[1] in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

[1] *Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.*

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IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS *NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid*, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Sign of a cold* sufferer
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Each Spansule® capsule contains 8 mg. Teldrin®
(brand of chlorpheniramine maleate);
50 mg. phenylpropanolamine hydrochloride;
2.5 mg. isopropamide, as the iodide.

Fast relief of upper respiratory congestion and hypersecretion* with convenient b.i.d. dosage.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.
Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} *Uptake:* Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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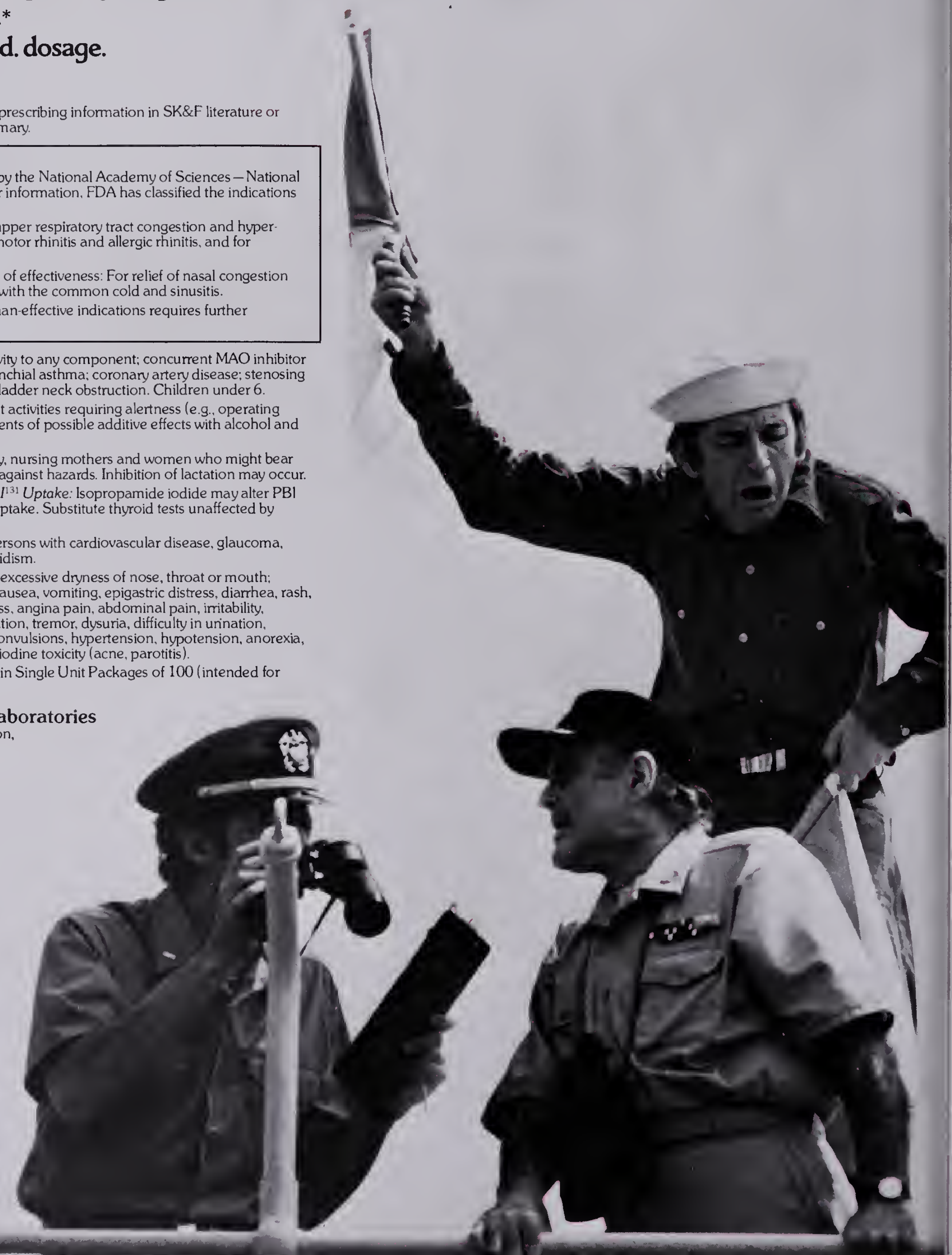
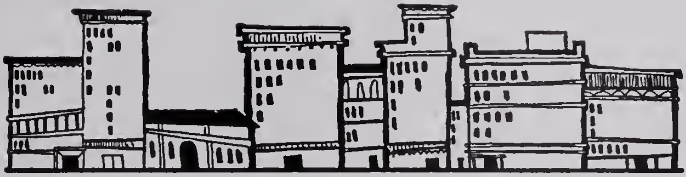


From the Medical Schools



UNIVERSITY OF MISSOURI-COLUMBIA

Dr. James O. Davis, chairman of the Department of Physiology has received the Franz Volhard Award with a $1,000 gift from the International Society of Hypertension. The presentation was made at the Society's recent meeting in Milan, Italy.

Dr. Davis was cited for his discovery in 1960 that the renin-angiotensin system controls aldosterone secretion in investigating the causes of hypertension or high blood pressure. He also was recognized for his contributions to the pathogenesis of hypertension.

In Milan, he gave the Franz Volhard Lecture on the use of blocking agents to study the functions of the renin-angiotensin system.

Dr. Davis is currently chairman of the medical advisory board of the Council for High Blood Pressure Research of the Amercian Heart Association.

WASHINGTON UNIVERSITY

Two Washington University School of Medicine researchers have received $320,321 to study the use of anticancer agents which will more effectively control the disease. *Teresa J. Vietti*, M.D., professor of pediatrics, and *Frederick A. Valeriote*, Ph.D., associate professor of radiology, are senior coinvestigators in the three-year National Cancer Institute study.

The Institute also is supplying more than $100,000 worth of mice yearly to be used in the chemotherapy experiments.

Dr. Vietti, project director, said the research is designed to find the best combinations and sequences of drugs to be used in therapy. "We hope to find the optimal program for killing cancer cells and, at the same time, establish a regimen that won't excessively damage normal tissue," she said. The study also will seek to determine if maximum cancer cell kill is obtained by single or multiple injections, or by slow intravenous infusions of a single drug.

A $60,507 grant from the National Institutes of Health will help Loretta K. Cass, Ph.D., determine if social and personal adjustments in adulthood can be predicted from assessment of childhood behavior, symptoms and clinical records.

Dr. Cass, assistant professor of medical psychology in child psychiatry, began making plans for this study in 1961.

To conduct this research, Dr. Cass will refer to clinical evaluations she and other faculty members at the Washington University Child Guidance Clinic made of patients visiting from 1961 to 1963. Then, the team will interview 250 of the same individuals in today's environment.

Dr. Cass also hopes to determine if the type and seriousness of adult mental illness and behavior disorders can be predicted from childhood variables. Of the 250 children rated and diagnosed, 72 will be reevaluated as adults using the same techniques that were used in their childhood.

ST. LOUIS UNIVERSITY

A number of physicians have received faculty appointments at the St. Louis University School of Medicine. *Dr. George E. Thoma*, vice-president for the Medical Center, has announced that *Dr. James E. Edwards* has been named associate clinical professor of psychiatry. Appointed as assistant clinical professors and their specialities were *Dr. Muhammad I. Chisti*, ophthalmology; *Dr. John Santilli, Jr.*, pediatrics; and *Dr. Herman Taute*, gynecology and obstetrics. Named assistant professors were *Dr. Werner H. Buettner*, molecular virology; *Dr. Thomas E. Dahms*, physiology; *Dr. Alice D. Kitchen*, psychiatry; and *Dr. Sarah J. Richards*, community medicine.

Dr. Rodney M. Coe, professor of community medicine, gave two lectures during the month of October. He spoke at Johns Hopkins University at the invitation of the Office of Health Studies, School of Health Service. His subject was "Some Measurement of Medical Student Attitudes." He also spoke at the University of Oregon on "The Role of Community Medicine in Medical Education."

Dr. C. Rollins Hanlon, 21st recipient of St. Louis University's Fleur-de-Lis Award and chairman of the University's Department of Surgery from 1950 to 1969, has been named the recipient of the Statesmen in Medicine Award which was scheduled to be conferred on October 8 at Airlie House in Airlie, Va. Dr. Hanlon is director of the American College of Surgery.

*We are pleased
to announce
that*

J. Bernard Finucane
Vice-President—Sales and Marketing

J. Bernard Finucane

was elected

PRESIDENT

of the

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For the Year 1974-1975 at the Annual
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The Council Reports

Meeting of Sept. 14, 1974

Max S. Franklin, M.D., St. Louis, Chairman, called the meeting to order. Those present were Drs. Franklin; James C. Cope, Columbia; R. Allen Chandler, Kansas City; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; E. A. Stricker, St. James; Lysle M. Bach, Hannibal; Louis P. Hetlage, Troy; Robert E. Bregant, Jefferson City; William D. Bradshaw, Clinton; Andrew McCanse, Kansas City; Howard J. McAlhany, Springfield; Claude W. Cooper, Thayer; Eugene T. Hansbrough, Poplar Bluff; Robert A. Slickman, Kansas City; James T. Brown, Springfield; Stanley S. Peterson, Springfield; Hector W. Benoit, Jr., Kansas City; J. Loren Washburn, Versailles; Hubert A. Ritter, St. Louis; M. Kenton King, William Stoneman, III, and George Thoma, St. Louis; Richardson K. Noback, Kansas City; William C. Allen, Columbia; Irving H. Clark, Kansas City; Herbert R. Domke, Jefferson City; Mrs. George J. Lytton and Mrs. William R. McPhee, Kansas City; Messrs. James L. Hamilton and Timothy J. Danis, St. Louis; Al Lerner, Chicago, Ill.; Hollister S. Smith, St. Louis; Gary L. Schnedler, Springfield; Allen D. Smith and Roger A. Weis, Kansas City; Messrs. Ray McIntyre, Royal O. Cooper, C. C. Swarens, Ron Ellison and Don Wilson, Staff.

On motion, duly seconded, the minutes of the May 25, 1974 Council Meeting were approved.

REPORT OF THE EXECUTIVE SECRETARY

Mr. McIntyre introduced Mr. Don Wilson who is the new Field Secretary for the Missouri State Medical Association.

Mr. McIntyre stated that Dr. Joseph Cope of Lexington and Dr. John Martin of St. Joseph have recently been appointed to the State Board of Registration for the Healing Arts by Gov. Christopher Bond.

Mr. McIntyre indicated that he would like to secure Council endorsement for a proposed Immunization Action Month. This was originally promoted by the U. S. Public Health Service and was endorsed by the AMA. The month of October has been designated by Governor Bond as Immunization Action Month in Missouri.

On motion of Dr. Bradshaw, duly seconded, it was agreed to give MSMA endorsement for the Immunization Action Month.

Mr. McIntyre reported that a Manpower Study Program is beginning operation in Missouri under the direction of Comprehensive Health Planning. The purpose of the program is to study in detail the health manpower needs of the state and then make recommendations as to what to do and what can be done. A task force has been appointed. Dr. Bradshaw is Chairman of the Task Force and Mr. McIntyre said that he had been appointed to serve on the Task Force with Royal O. Cooper as his alternate.

Dr. Hetlage suggested that an ad hoc committee of the Commission on Medical Economics review the reports of the Task Force which is studying health manpower.

On motion of Dr. Hetlage, duly seconded, it was agreed to request that the reports of the Task Force studying health manpower be made available to an ad hoc committee of the Commission on Medical Economics for review of the activities and information which have been compiled.

Mr. McIntyre reported that the AMA will hold a Continuing Medical Education Conference on October 2-3 at the Drake Hotel in Chicago. Dr. Paul Young and Mr. Ron Ellison will attend the conference.

Mr. McIntyre stated that Dr. John Laird, President-Elect of the St. Louis County Medical Society, has sent out invitations to the officers of the county medical societies for a meeting that will be held at Tan-Tar-A in October. This will not be a formal meeting, but it will be a discussion session of the problems facing county medical societies.

REPORT OF THE TREASURER

Dr. Judd reported that in the Executive Session on Friday night, there was a discussion of the Association's 1974 financial operations through August 31, 1974 in an itemized fashion. There are some items that are not in line with our 1974 adopted Budget primarily because of the extent of inflation which was not fully anticipated by the Budget Committee last December in proposing the 1974 Budget. This was to be a deficit budget, anticipating a deficit of about $5,000. We now anticipate a deficit in the range of $10,000.

REPORTS OF DISTRICT COUNCILORS

District #2—Dr. Bach stated that a mental health center is now operating in his area. A pediatric intensive care unit has been opened in a hospital in Hannibal.

District #3—Dr. Franklin called on Dr. Judd to discuss the possible amalgamation of the St. Louis Medical Society and the St. Louis County Medical Society.

Dr. Judd stated that both societies have discussed the possibility of amalgamation for several years. Both societies were surveyed by an AMA survey team last year and amalgamation was recommended. The societies established a joint committee to look into the feasibility of combining. This committee of both societies recommended amalgamation. The Executive Councils of both societies have voted for amalgamation. A vote of the membership of both societies will be held on October 15.

District #4—Dr. Hetlage presented and then withdrew the following resolution after consultation with the AMA Delegates who indicated that this was redundant as this is already AMA policy:

> *Resolved,* That the Council of the MSMA go on record as resolutely favoring a stance by the AMA with the Federal Government which would require a means for balanced fiscal funding to be written into any proposed legislation for national health insurance or any other medically oriented proposals; and be it further
>
> *Resolved,* That this resolution be conveyed to the AMA House of Delegates for its consideration and action.

Dr. Hetlage presented several reasons why the Fourth Councilor District objected to the new proposed Missouri Uniform Hospital Discharge Data Program.

He stated that representatives from CEMPROC attended his Fourth District Conference on September 4 and presented an interesting discussion of that new organization.

A discussion on the amalgamation of the St. Louis City and St. Louis County societies was held at the Fourth District Conference. Also, a discussion was held on CME and compulsory relicensure and on the report of the MSMA Commission on Medical Economics.

Dr. Hetlage stated that a lively discussion was held at his

District Conference regarding the actions of the MSMA Ad Hoc Committee of the Council on Family Planning, of which he is Chairman. There have been objections of interference expressed by the St. Louis Family Planning Council. This Family Planning Council, in general, is firmly in control of the medical profession and is doing an excellent job without apparent interference of the private practice of medicine in this area. He indicated that it was felt that the report of the Ad Hoc Commitee on Family Planning left the impression with the St. Louis Family Planning Council that we favored the dissolution of this Council and the assumption of this function by the State Health Department. Dr. Hetlage stated that, unintentionally, this was the impression that was given in the report. He indicated that he felt is was in order for him, as Chairman of the Ad Hoc Committee on Family Planning, to apologize to the St. Louis Council.

The matter of professional liability insurance was discussed at the Fourth District Conference. Dr. Hetlage indicated that it was felt that the principle of contingency fees on the part of the legal profession to be a definite cause for the rise in malpractice suits and, thereby, the vast increase in the cost of professional liability insurance. He stated that, perhaps, a committee composed of physicians and lawyers should attempt to study and arbitrate all claims for medical malpractice and that the cost of malpractice insurance would be greatly reduced by such action.

Dr. Hetlage reported that those members present who had been newly appointed to commissions and committees expressed a strong desire to have their duties on these commissions and committees defined so that they may more adequately carry out their responsibilities.

Dr. Hetlage stated that he had attended the June AMA Annual Meeting and was appreciative of the willingness on the part of the Missouri Delegation to include him in their activities and of seeing the operation of the delegation from the inside.

Dr. Hetlage suggested that in order to increase the prestige of our delegation, following the lead of Texas and other delegations who were immediately identifiable because of their uniform dress, funds be made available to purchase coats of a uniform color with a suitable breast pocket patch for each of our delegates and alternates and that society officers, and executives be similarly attired. Dr. Franklin stated that the matter of coats for AMA delegates, alternates, society officers and executives would be referred to the Planning Committee.

District #5—Dr. Bregant reported that an office for the Mid-Missouri PSRO Foundation had been set up in Jefferson City and that it now has an Executive Secretary. Dr. Paul Young is the project director and they are now formulating membership applications, etc.

District #6—Dr. Bradshaw stated that he had no report to present at this time.

District #7—Dr. McCanse reported that the Northwest Missouri PSRO now has a planning grant and is in the process of contacting medical societies and hospitals and acquainting them with PSRO and recruiting membership in the PSRO organization.

Dr. McCanse stated that at the last Council Meeting, he had reported on Medical Systems, Inc. This group was incorporated by some members of the Jackson County Medical Society to attempt to provide physicians services to large industries in the Kansas City area.

Dr. McCanse reported that the greater Kansas City Medical Society *Bulletin* had undergone a face-lift recently and he asked that it be sent to each member of the Council. Dr. Hansbrough stated that he would like to receive all Missouri county medical society bulletins. Dr. Ritter asked that the AMA delegates be included on the list of those receiving county medical society bulletins.

District #8—Dr. McAlhany stated that his Eighth Councilor District meeting would be held in Joplin on October 8. Dr. Cope will be the speaker. The PSRO in Southwest Missouri has had several organizational meetings and plans to file for a planning grant.

Dr. McAlhany called on Mr. Gary Schnedler to talk about the new Greene County Medical Society Executive Office. Mr. Schnedler indicated that the present Executive Office of Greene County was too small and that they would move soon into larger quarters. He invited everyone to see the new office.

Dr. Franklin thanked Dr. McAlhany for taking over for him at the May Council Meeting.

District #9—Dr. Cooper stated that a doctor in his area had conducted a poll in regard to compulsory membership in AMA. A total of 47 letters were sent and 44 responses were received. Of the 44 responses, 41 disapproved of compulsory membership in AMA.

Dr. Cooper indicated that there is interest in his area in developing MSMA group professional liability insurance for members as quickly as possible.

District #10—Dr. Hansbrough reported that a meeting of the National Emergency Physicians was held recently in his area. This was an excellent meeting and is to be an annual affair.

Dr. Hansbrough stated that his group is moving into a new clinic building soon and invited everyone to see it.

The SEMO PSRO Foundation has been in operation for some time and has several people who are knowledgeable about this. Dr. Hansbrough stated that if any other PSROs would like advice, there are several people there who will be willing to advise them.

Dr. Hansbrough stated that he felt that public health departments should make greater inroads in how to improve people's health through nutrition. Dr. Bradshaw indicated that a National Conference on Nutrition will be held in Columbia in October. Dr. Hansbrough indicated that he felt that there is not enough public health nursing services and that public health should come up with improved ways of informing people of the dangers of smoking, drugs, alcohol, etc.

Dr. Peterson stated that the Extension Division of the University of Missouri, in conjunction with the Health Department and the Medical School, has been having seminars on nutrition in his area.

REPORT OF AD HOC COMMITTEE TO STUDY GROUP PROFESSIONAL LIABILITY INSURANCE

Dr. Irving H. Clark, Chairman of the Commission on Medical-Legal Affairs and of the Ad Hoc Committee to Study Group Professional Liability Insurance, stated that he became involved with this committee approximately four years ago. He stated that, originally, it was felt that Missouri did not have a problem with professional liability insurance, but recommended that a reappraisal of our situation be made if events should change.

Recent developments have made it apparent that we must consider the trend of various underwriting companies in the state of Missouri relative to professional liability insurance. It has become increasingly apparent that the trend of the insurance companies seems to be toward insuring groups of physicians. This is in either county or state associations. It was felt that merely copying one of the plans of other states would be a mistake. Therefore, further study was made.

After interviewing representatives of insurance firms from both Kansas City and St. Louis and other parts of the state who were interested in providing insurance on a statewide basis, the plan which interested us most after the evaluation and study of all was one which would enable the Missouri State Medical Association to evolve a program of professional liability insurance for member physicians which meets several criteria which we had established early in our deliberations. First, it involved the formation of a corporation to be known as the Missouri State Medical Insurance Plan, which should be recognized by Missouri state laws governing insurance sales, that would be administered first of all by the Missouri State Medical Association, with the expertise of management to be provided by this particular firm. Arrangements were to be made to serve other members of the state by means of wide area telephone service.

The administration of the plan should include the promotion of sales of insurance to the membership; the receipt of applications for insurance and necessary processing thereof; the binding of insurance for eligible members consistent with such binding authority as is afforded by the insurance carrier to that company; the delivery of issued policies along with invoices for the premiums; the collection of the premium from the individual insureds; the assistance in the procurement of financing of premiums for individual physicians as may be requested; the routine service of policy changes, such as cancellations, endorsements, claim reports from the physicians and routine service for the individual physician in all matters relating to the insurance policy; the underwriting of the program to be delegated by the insurance company; assistance in the coordination of activities of the Plan; issuance of policies and endorsement thereto with copies to MSMA to the extent desired by its staff; the preparation of accounting records for the insurance company with copies to MSMA to the extent desired by its staff; the handling of all insurance company-agency relations pertaining to the program; the preparation and maintenance of all statistical records with copies of such records to MSMA; the receipt and disbursement of commissions from the insurance company; the provision of advisory service to MSMA to the extent requested; and the general supervision of the Plan to satisfy the requirements of the insurance company.

Responsibilities of MSMA should include the active promotion of new member participation. Needless to say, the previously mentioned responsibilities are those pertaining to the insurance company as a sponsored company with the insurance broker as an active participant. MSMA would promote new membership and be responsible for the performance of liaison services between its members, the plan and the broker, the maintenance of records as required by the plan, the establishment and maintenance of professional liability education program for all members of the association, for it is clear that herein lies the real cure to malpractice litigation problems.

Also, MSMA, as part of its obligation in addition to education for its members, must provide a claims review using independent legal counsel, the cost to be borne by the insurance company, and medical consultant service as deemed necessary to properly serve the individual policyholder and the professional review of the program.

As I go through in my mind the many provisions which were worked out in agreement form with this particular company, several things stand out—that this agreement should remain in effect until it is cancelled; further that the agreement could be cancelled by either member with six months notice prior to January 1 of any calendar year. Now, this does not mean that the insurance is cancelled. It merely makes it possible for MSMA, if dissatisfied, to obtain another administrator or for the administrator to notify us that they desire that we obtain a replacement for them in management of the company. The broker who has advanced this program agrees to join with MSMA in the joint formation of such a corporation and to be responsible for the services described herein under the agreement submitted on a percentage distribution of stock or on a program wherein they would be hired as the administrators of the program for a specified fee. For those of you who are acquainted with the Florida Medical Association program, this is very similar to their program which calls for a 51% ownership by the Florida Medical Association and 49% by the broker involved.

Dr. Clark indicated that this research program was done by Mr. James Hamilton, Vice-President of Rollins Burdick Hunter Company. Rollins Burdick Hunter is the fourth largest insurance broker in North America and is a multinational company. It has a top rating with investment bankers. They are professional buyers and managers of insurance.

Dr. Clark stated that the ad hoc committee is recommending very strongly the concept of the formation of a sponsored insurance corporation, a separate corporation in partnership with RBH or with RBH as manager, for the provision of a professional liability program and/or other related insurances to MSMA members and that they be empowered to continue studies and negotiations necessary to bring about the formation of such a corporation.

Dr. Clark stated that Mr. James Hamilton was in attendance at the meeting and he would like to turn the floor over to Mr. Hamilton for further information and to answer questions.

Mr. Hamilton expressed his thanks to Dr. Clark and to Dr. McAlhany, both of whom have worked with Rollins Burdick Hunter. Mr. Hamilton indicated that what was presented was an interim report. Rollins Burdick Hunter received the following ten charges from the ad hoc committee:

1. Make various assumptions of premiums and losses; examine choices of insurance carriers.
2. Examine various models of allocations of expenses, reserves and premiums, including amortization of acquisition costs.
3. Examine methods of Cash Flow as related to reserving including retrospective rating, dividends, reserve reduction.
4. Construct a Pro Forma financial estimate for five years for the captive agency including profitability cash flow, investment program.
5. Construct the design of plans and policy language relating coverage and eligibility to rate structure and salability and losses.
6. Design principal features of a marketing plan including advertising, brochures, testing, pricing, including cost of acquisition.
7. Design principal features of the administration including services to members, policy issuance, claims handling, premium collection.
8. Comment on data processing, systems required and software; cost to set up; amount of monthly time.
9. An overall critique from retained mass merchandising advisors.
10. A report from retained attorneys regarding the various legal aspects of a captive agency.

Mr. Hamilton stated that Missouri has a number of characteristics somewhat unique from most other states in regard to the malpractice situation. Mr. Hamilton then reviewed various exhibits that had been presented to the Officers and Councilors and answered numerous questions concerning all phases of their proposal.

A motion was made by Dr. Bradshaw to approve this report and acceptance of RBH to continue to evolve this program in cooperation with the ad hoc committee and MSMA.

The motion was seconded by Dr. Hetlage and carried.

REMARKS OF THE PRESIDENT

Dr. Cope stated that he had received many comments on his President's Page in the September issue of Missouri Medicine.

He reported that a group of cardiologists from Kansas City had circularized hospitals in the state offering their cardiology services. Dr. Cope indicated that he felt it would be better for hospitals to request this service rather than to be solicited.

Dr. Cope said that it had come to his attention that a physician in St. Louis was having problems with Medicare in regard to retroactive denial of payments. Dr. Cope stated that he had suggested to the physician that he get a copy of the disallowed claims and submit them to the Health Care Foundation for review. It was suggested that, perhaps, these cases could be submitted to this doctor's hospital utilization review committee.

Dr. Judd said that if either of the above suggestions proved to be unsatisfactory, perhaps the doctor involved could submit these cases to the Commission on Medical Economics for an impartial survey.

It was moved and duly seconded that the above matter concerning retroactive denial of payments to a St. Louis physician be referred to the Commission on Medical Economics.

The motion carried.

REMARKS OF MEDICAL SCHOOL DEANS

Dr. King reported that the Washington University School of Medicine recently admitted a freshman class of 120.

Dr. William Allen reported that Dr. Joseph White asked him to express his regrets for not being able to attend the Council meeting and, also, to express his appreciation to MSMA for support of him for reelection to the AMA Council on Medical Education.

Dr. Allen stated that Dr. Mayer had resigned as Dean of the Medical School. He indicated that Dr. Mayer wished to express his appreciation to the Council for providing the opportunity to meet with them and for the assistance to him in the years he was Dean. A search committee has been appointed to secure a new Dean.

Dr. Allen reported that Dr. Vernon Wilson has accepted the position of Vice-Chancellor for Health Affairs at Vanderbilt.

Missouri University School of Medicine has an entering class of 110 students and approximately one half of these students came from rural areas of Missouri.

It was moved, seconded and carried that President Cope be asked to write a letter to Dr. Bill Mayer indicating appreciation for his attendance, advice and counsel at Council Meetings over the past years.

Dr. Stoneman, St. Louis University, reported on enrollment at the University stating that the current freshmen class numbers 151, of which 52 are Missourians.

The search for a Dean of St. Louis University School of Medicine is continuing. A Chairman of Internal Medicine has been hired and will begin in January.

The University expects to begin construction on the learning resources center and it is anticipated this will have a large continuing education function at the University. There is a problem of funding for the University portion of this.

Dr. Noback reported that the University of Missouri-Kansas City has enrolled 72 medical students in year one. He stated that several new staff appointments have been made. Dr. McCanse has been named Associate Dean in the School of Medicine. Dr. Noback indicated that he felt that the University's preceptor program is going very well.

The University of Missouri-Kansas City School of Medicine was awarded a ¾ million dollar grant from HEW to put in place a major program to measure the competence of primary care nonphysician practitioners.

Dean Noback reported that they are now in the new Medical School Building and extended an invitation to all present to visit the School. The Truman Medical Center, a 308-bed hospital, should be completed in about two years.

Dr. Noback indicated that the Jackson County Medical Society has given him a page in their *Jackson County Bulletin* and he is certainly appreciative of this.

REMARKS OF THE DIRECTOR, MISSOURI DIVISION OF HEALTH

Dr. Domke spoke on the Division of Health's involvement in the manpower study field, indicating that they are aware of the $400,000 grant to CHP, but that the Division of Health has no control over it. The Division is currently in the process of a nurses' manpower analysis.

Dr. Domke reported that a group interested in the clinical facilities in Columbia is working to formulate a national, regional cancer center. He is hopeful that papers will have been negotiated by the time of the next Council Meeting.

Dr. Domke has received from HEW a statement concerning the family planning situation in Missouri. It was suggested that the Association obtain a copy of this statement.

Dr. Domke reported that he understood many questions had arisen regarding the Division of Health proposal for collection of hospital discharge data. He stated that the issue of confidentiality seemed to be the uppermost issue. Dr. Domke said that the Division of Health has been collecting hospital discharge data for ten years in cooperation with the Missouri Hospital Association. Approximately 75% of the hospitals have been submitting data. The hospital associations in Missouri were consulted and agreed to cooperate in a mandatory program in order that data would be available for planning of facilities and epidemiologic research. We will not collect names of patients and there is no provision to collect a unique identification number and we will only collect a census tract code. Dr. Domke indicated that the Division of Health is very conscious of the right of privacy and the confidential nature of the data. However, it has been responsible for collecting confidential birth, death and communicable disease records for many years and no violation of confidentiality has occurred.

Dr. Domke said that the previous reporting system known as "Icepick" provided good data from the rural areas, but not the metropolitan areas.

It is clear that there is an increasing interest in hospital planning and construction and the need to control hospital costs and cut down on unnecessary duplication. This is the basic justification for the program.

Much discussion followed regarding the confidentiality of the data collection process, the cost of this program to the hospitals, the usefulness of the data, etc. Dr. Franklin reported that a physician in his area had requested and received a legal opinion regarding the confidentiality of this program. Dr. Bradshaw indicated that he felt the data that is being accumulated will be utilized in such a way as to influence physician manpower and has further-reaching impact.

REPORT OF COMMISSION ON MEDICAL ECONOMICS

Dr. Stanley Peterson, Chairman of the Commission on Medical Economics, Third Party Medicine and Governmental Relations, gave the following report concerning his Commission meeting held on Aug. 7, 1964.

Dr. Max Heeb was appointed Chairman of an ad hoc committee to study and implement the resolution approved by the MSMA House of Delegates concerning the negotiation of a definite fee schedule for physicians providing care for Title XIX recipients and further negotiating a list of ancillary services that will be covered for payment by the Missouri Division of Family Services. The legal implications involved in implementing this resolution were discussed at length. The Commission endorsed the principle that under no circumstances should physicians' fees be established solely on the basis of geographic location. The ad hoc committee was directed to obtain from state Medicaid officials a list of items, services and procedures for which providers may not be reimbursed under the Medicaid program.

The Commission discussed disproportionate fees being paid to those in private practice versus those paid to organized clinics and medical school settings. The Chairman will appoint an ad hoc committee to investigate and authenticate any disproportion of fees paid under Medicaid.

The Commission discussed Medicare Bulletin #3, "Waiver of Liability," as issued by fiscal intermediaries in April, 1974 to implement the 1972 Medicare amendments that basically provide that a beneficiary may be "held harmless" for disallowed claims when certain conditions are met. It was the consensus that the category of nonreimbursable services is quite vague and staff was directed to contact the fiscal intermediary and attempt to obtain a list complete with codes of items and services that are considered not reimbursable and, also, to determine from Medicare officials what items and services are considered to be effective and what items and services are considered to be not effective.

Resolution #14, entitled "Involvement of Third Parties in the Practice of Medicine" and adopted at the 1974 Session of the House of Delegates, was referred to the Medical Economics Commission. This resolution states "that all persons or organizations be informed that decisions involving physician care must be discussed with the involved physicians or their representatives before such changes are made."

The Commission recommends that a letter be drafted by staff and directed to all third parties including the federal government, fiscal intermediaries, insurance companies and hospitals. This letter will request them to develop mechanisms that will provide for the involvement of physicians in all decisions involving physicians care before such rulings changes and decisions are made. They should be requested to advise MSMA of the mechanism they have developed to implement this.

The Chairman of the Commission on Medical Economics will appoint an Ad Hoc Governmental Relations Committee in an effort to stay abreast of rapidly changing government programs. This committee will be appointed on a regional basis.

The Commission has attempted to obtain codes from various carriers to enable individual physicians to determine coverage of health insurance benefits. To date, this attempt has been quite unsuccessful, however, staff has been directed to continue this effort as an ongoing project.

Dr. Peterson reported that the Commission has worked for the development of a uniform claim form for accident and health insurance for many years. In 1973, the AMA Health Insurance Claim Form was developed. There was some objection to the statement on the reverse of the form, but this is now being corrected and a new form is available from AMA. Staff was directed to obtain the new forms and send them to all members of the Commission for review and, also, to obtain an opinion from legal counsel concerning this form. It is the Commission's understanding that if a carrier receives a Medicare claim executed on the AMA form it will be processed if it contains the information called for on the appropriate SSA-1490.

The Commission on Medical Economics recommends that an Ad Hoc Committee be appointed to develop a communications program for members and citizens of this state concerning National Health Insurance. Their activities would include articles for the press and other state publications, articles in Missouri Medicine and a speakers bureau.

The Commission discussed the work of the Missouri State Senate Committee which is conducting hearings throughout the state reviewing the welfare programs. Dr. Peterson developed testimony documenting slow payment to providers for services rendered under Medicaid and on the disparity of payment of physicians for identical procedures and services provided under Medicaid.

The final item discussed by the Commission concerning the Retail Credit Company handling of privileged information between doctor, patient and insurance company. They act simply as carriers between the physician and the insurance company and their files contain only a control sheet listing the source of information and the date it was sent to their customer. They also have indicated their willingness to cooperate with physicians. Staff was directed by the Commission to commend Retail Credit Company for their thoughtfulness in contacting organized medicine and explaining their procedures and to further indicate approval of their handling of privileged information.

A discussion was held following Dr. Peterson's report to the Council and it was suggested that regarding endorsement of the principle that under no circumstances should physicians fees be established solely on the basis of geographic location. Possibly, this should include training.

On motion, duly seconded, it was agreed that the ad hoc committee to develop a communications program for members and citizens of this state concerning National Health Insurance should be assigned to the Commission on Medical Economics.

On motion, duly seconded, the entire report of the Commission on Medical Economics, Third Party Medicine and Governmental Relations was approved.

REPORT OF THE COMMITTEE ON PLANNING

Dr. Cope reported that the Committee on Planning met on August 24, and discussed the importance of long-range planning for the Association. It was the consensus of those present that the work of this committee involves (1) Formulation of long-range goals; (2) Specification of operational objectives; (3) Anticipation of problems; (4) Identification and selection of strategies; (5) Adoption of appropriate policies.

The Committee discussed Resolution #38—Constitutional Convention—which was referred to the Committee on Planning by the 1974 House of Delegates. The possible amalgamation of the two St. Louis Societies was discussed and it was felt by those present that the amalgamation, if completed, would require some reorganization of Councilor Districts and that there is no need to consider a constitutional convention at this time because of the amalgamation situation.

The Committee directed staff to finalize plans for recognition awards for members. Staff will select the type of award to be given and these will be presented to outgoing officers, councilors, AMA delegates, AMA alternate delegates, committee and commission members.

Dr. Cope reported that the Committee recommends that the Committee on Arrangements considers the feasibility of changing the format of our Annual Session. The Committee suggests that Past-Presidents and 50-Year members be honored and recognized at the Saturday general luncheon rather than during the Annual MSMA Banquet on Saturday night and that the media awards also be given at this luncheon.

The Committee recommended going ahead with the New MSMA Policy Manual and that it be revised annually. It al-

(Continued on page 660)

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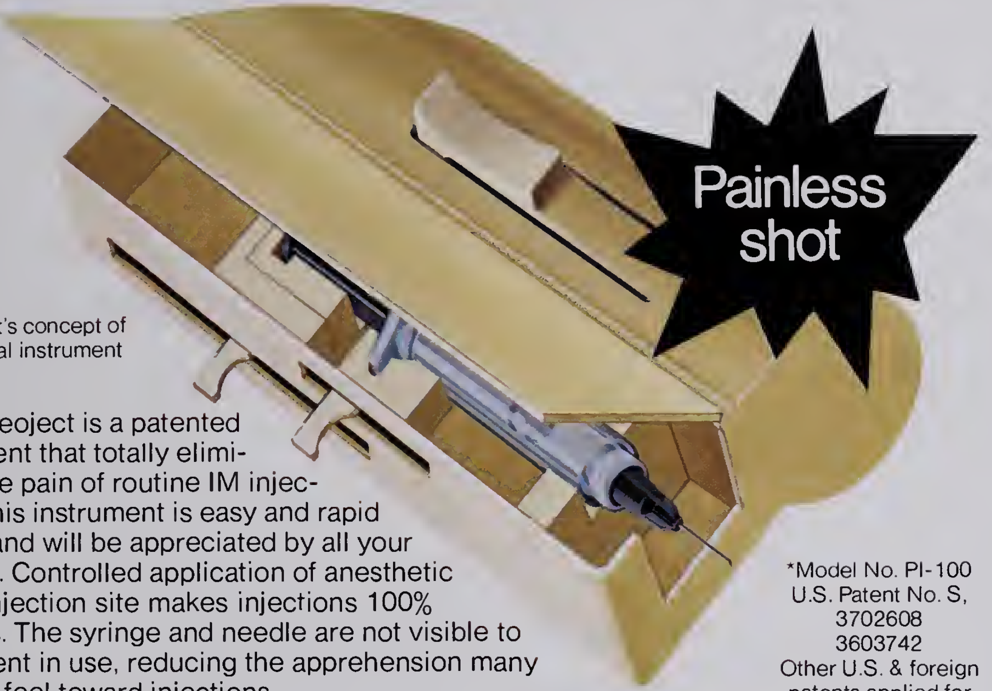

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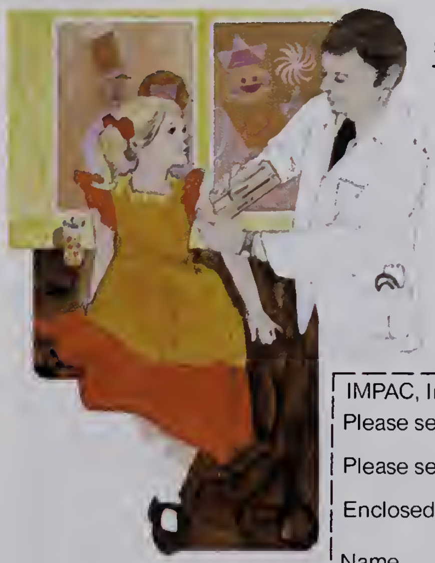

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Hypertension Revisited

A Method of Evaluation

Systemic hypertension represents a major threat to longevity in the adult American population. The indolent nature of this disease process leads to a sense of complacency about therapy for hypertension on the part of the patient and, at times, the physician as well.[1] Early detection and aggressive therapy have been clearly shown to reduce the morbidity and mortality associated with uncontrolled hypertension.[2]

Antihypertensive drug therapy is the principal modality used to control hypertension. In many instances, blood pressure control is erratic, often due to the unreliable use of prescribed drugs by the patient. At times, however, adequate and consistent control is difficult in spite of conscientious drug therapy. Careful evaluation of hypertensive patients will reveal an estimated 5% to 10% who have a surgically correctable cause for their hypertension. Surgical treatment in this group of patients will cure or significantly improve the management of their hypertension.

Thorough evaluation of every hypertensive patient would be ideal, but this may not be practical in view of the broad scope of the problem. Complete evaluation is mandatory in good-risk patients who are inadequately controlled with drug therapy. The higher the blood pressure and the younger the patient, the greater the relevance of this evaluation.

An outline of the method for evaluation of hypertensive patients used at this medical center is the subject of this report.

Detection

A blood pressure of 140/90 is considered by most physicians to be the upper limit of normal. One blood pressure determination above this level would not warrant extension of the initial office evaluation, which should include chest x-ray, electrocardiogram and urinalysis. Consistent evaluation of the blood pressure on three separate determinations at weekly intervals should be an indication for further diagnostic and therapeutic efforts (Fig. 1). The patient who represents an unacceptable surgical risk would best be controlled with drugs with no effort to search for a surgically correctable cause and will be considered no further in the discussion. A more aggressive approach should be taken in the evaluation of younger patients. A diligent search for surgically correctable lesions should be made in patients under 50 years of age. Many patients over 50 years of age and with moderate or severe hypertension in spite of intensive drug therapy also will warrant the same approach.

Uncontrolled diastolic hypertension represents a major threat to health in the adult American population. However, adequate control of hypertension has been shown to reduce this threat. The information in this paper emphasizes the importance of evaluating certain hypertensive patients and describes a method of evaluation which the authors consider to be practical. The authors are from the Department of Medicine, Section of Nephrology and the Department of Surgery at St. Luke's Hospital and the University of Missouri-Kansas City School of Medicine.

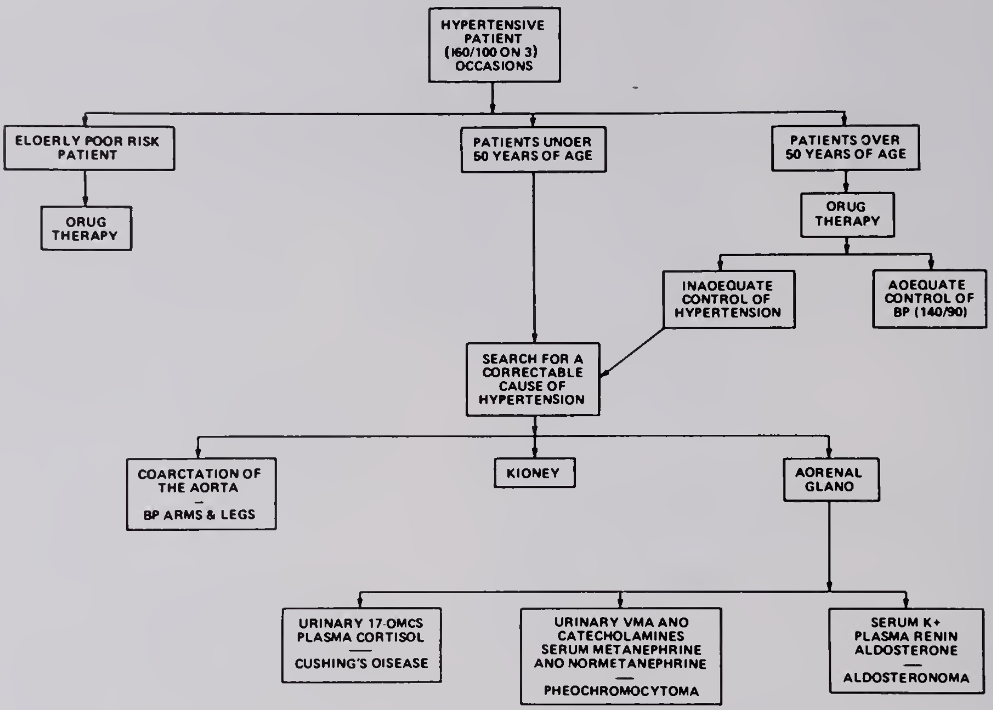

HYPERTENSIVE PATIENT (160/100 ON 3) OCCASIONS
ELDERLY POOR RISK PATIENT
DRUG THERAPY
PATIENTS UNDER 50 YEARS OF AGE
PATIENTS OVER 50 YEARS OF AGE
DRUG THERAPY
INADEQUATE CONTROL OF HYPERTENSION
ADEQUATE CONTROL OF BP (140/90)
SEARCH FOR A CORRECTABLE CAUSE OF HYPERTENSION
COARCTATION OF THE AORTA — BP ARMS & LEGS
KIDNEY
ADRENAL GLAND
URINARY 17-OHCS PLASMA CORTISOL — CUSHING'S DISEASE
URINARY VMA AND CATECHOLAMINES SERUM METANEPHRINE AND NORMETANEPHRINE — PHEOCHROMOCYTOMA
SERUM K+ PLASMA RENIN ALDOSTERONE — ALDOSTERONOMA

Fig. 1

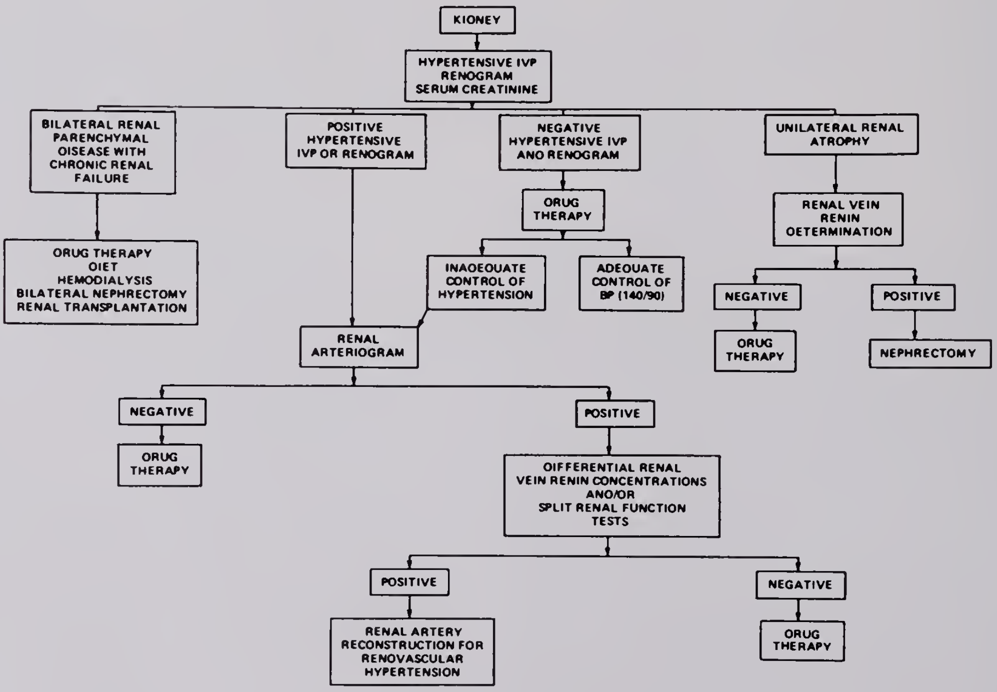

KIDNEY
HYPERTENSIVE IVP RENOGRAM SERUM CREATININE
BILATERAL RENAL PARENCHYMAL DISEASE WITH CHRONIC RENAL FAILURE
DRUG THERAPY DIET HEMODIALYSIS BILATERAL NEPHRECTOMY RENAL TRANSPLANTATION
POSITIVE HYPERTENSIVE IVP OR RENOGRAM
NEGATIVE HYPERTENSIVE IVP AND RENOGRAM
DRUG THERAPY
INADEQUATE CONTROL OF HYPERTENSION
ADEQUATE CONTROL OF BP (140/90)
UNILATERAL RENAL ATROPHY
RENAL VEIN RENIN DETERMINATION
NEGATIVE
POSITIVE
DRUG THERAPY
NEPHRECTOMY
RENAL ARTERIOGRAM
NEGATIVE
DRUG THERAPY
POSITIVE
DIFFERENTIAL RENAL VEIN RENIN CONCENTRATIONS AND/OR SPLIT RENAL FUNCTION TESTS
POSITIVE
RENAL ARTERY RECONSTRUCTION FOR RENOVASCULAR HYPERTENSION
NEGATIVE
DRUG THERAPY

Fig. 2

EVALUATION

The scheme which is outlined (Figs. 1 and 2) is centered around a search for the surgically correctable causes for hypertension. Coarctation of the aorta is a well-known cause of hypertension in children, but it is rare in adults. Determination of blood pressure and palpation of pulses in the arms and legs would help to establish its absence. Aortography would be indicated in the rare incidence when it is strongly suspected.

The adrenal gland (Fig. 1) is the source of three very interesting, though unusual, causes for hypertension. Hyperfunctioning states of the adrenal cortex result in Cushing's disease and syndrome and hyperaldosteronism, while the pheochromocytoma arises from the adrenal medulla. The clinical evaluation combined with relatively simple blood and urine tests provide accurate detection of these diseases. In Cushing's disease and syndrome, the addition of 24-hour urinary 17-hydroxy corticosteroid determination to the clinical picture will allow accurate early detection. An aldosterone secreting tumor is suggested in the hypertensive patient with muscular weakness and a serum potassium level of less than 3.5 mEq per liter while on no diuretics. Determination of the peripheral venous renin level will further define the presence of such a tumor. The value of this determination is augmented by salt and water depletion in the patient with the use of diuretics and by having the patient in the standing position for two to three hours prior to obtaining the blood sample. Peripheral venous renin levels are maximally stimulated by these measures in normal individuals. The patient with primary hyperaldosteronism will have a suppressed peripheral venous renin level in spite of maximal stimulation. This diagnosis can be further substantiated by determination of serum aldosterone levels although this assay is less readily available than the renin assay.

Episodic hypertension with severe headaches is suggestive of the presence of a pheochromocytoma. This can be accurately evaluated with determination of 24-hour urinary catecholamines and Vanillylmandelic acid. An accurate drug history is important in interpreting these values as certain drugs may be responsible for abnormal elevations. Direct determination of serum levels of metanephrine and normetanephrine may be useful where urinary values are obscured by drug therapy. The simplicity of the evaluation warrants its use in every patient with significant hypertension, whether episodic or sustained.

This very brief discussion of the adrenal causes of hypertension is intended to outline simple, readily available tests for detection of these disorders. When this evaluation indicates the presence of one of these diseases, complete evaluation with localization of the adrenal pathology with such measures as intravenous pyelogram and aortogram is necessary. A detailed discussion of this evaluation is beyond the scope of this paper.

Abnormalities of the kidney and its blood supply are the most common surgically correctable causes of hypertension (Fig. 2). Stenosis of the renal artery is the single, most-common cause of surgically correctable diastolic hypertension. Although its incidence is unknown, it is estimated at 5% to 10% of the patients with diastolic hypertension. Evaluation for possible renal causes of hypertension should routinely include urinalysis, urine culture, serum creatinine, creatinine clearance, serum electrolytes and a "hypertensive" intravenous pyelogram. This intravenous pyelogram (IVP) differs from the standard technique in that the contrast media is injected rapidly enough to obtain a film at 30 to 60 seconds at a time prior to dye appearance in the collecting system. Films are obtained at intervals of one minute for the first five minutes and in a routine manner thereafter. In addition to detection of abnormalities in renal parenchyma and collecting system, the hypertensive IVP is the best and most accessable screening test for renal artery stenosis. Changes in the "hypertensive IVP" which suggest renal artery stenosis are listed below. The first two are the most objective.

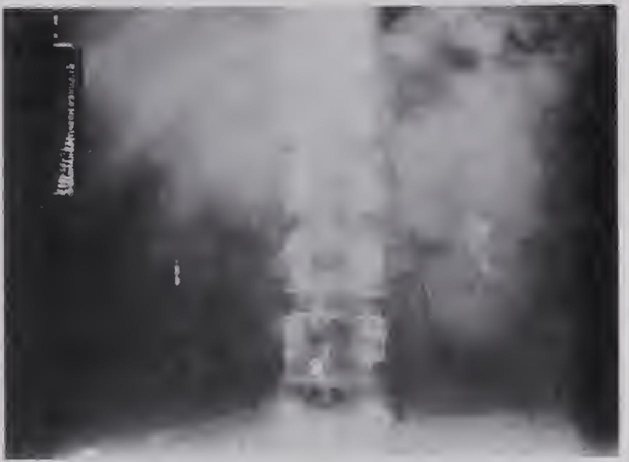


Fig. 3 Hypertensive intravenous pyelogram in this 45-year-old woman is positive for renal artery stenosis. This three-minute film shows a clear delay in dye appearance in the right kidney which also was 2 cm smaller than the left kidney in the pole-to-pole diameter.

1. Delay in time of appearance in the contrast material on the affected side (Fig. 3).
2. Greater than 1.5 cm difference in the pole-to-pole diameter with smaller kidney on the affected side (Fig. 3).
3. Hyperconcentration of the contrast media in the collecting system on the affected side.

The only single test which can conclusively rule out the presence of renovascular hypertension is arteriography. The routine use of renal arteriography in all hypertensive patients is impractical and inappropriate. The "hypertensive" IVP and isotope renogram should be used instead as screening tests to detect those patients who require renal arteriography. Renal arteriography is clearly indicated in the presence of an abnormal finding in an IVP or renogram with changes suggestive of renal

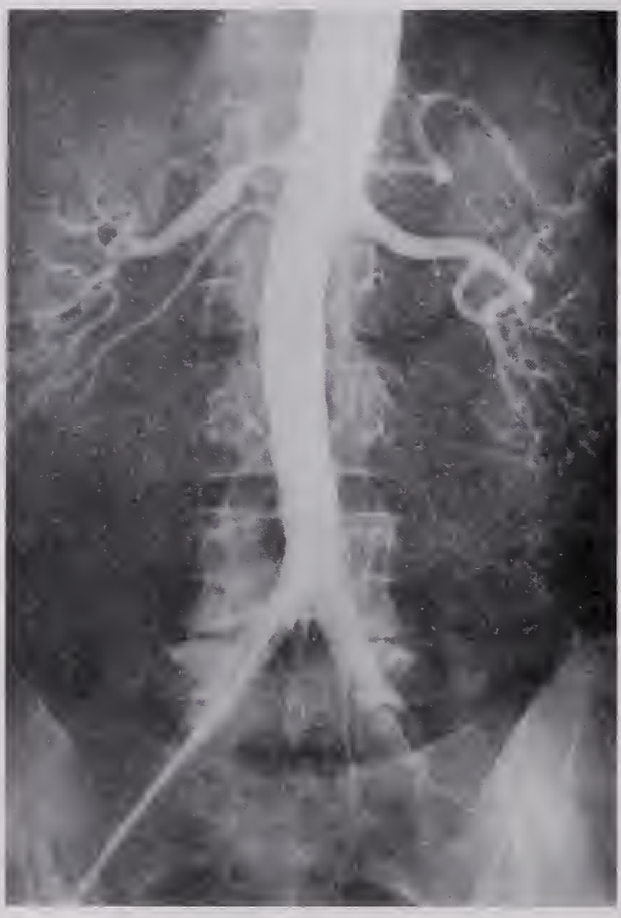


Fig. 4 Flush abdominal aortogram in a 54-year-old woman shows a stenotic lesion in the proximal third of the right renal artery with poststenotic dilatation of the renal artery. Atherosclerosis was the cause of this stenotic lesion and typically occurs in this location. Functional significance was proven with renal vein renin determinations and the patient was treated with right aortorenal bypass graft. She is now normotensive.

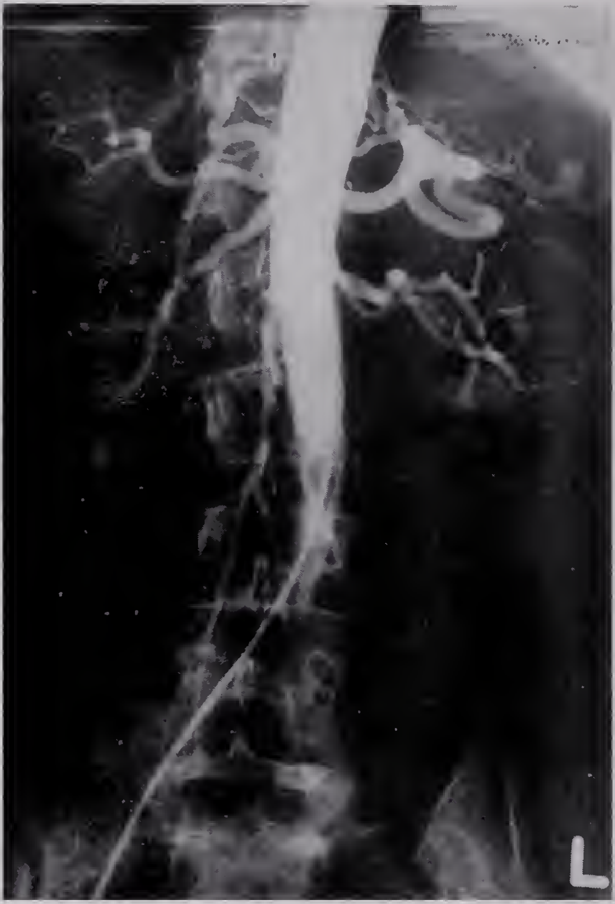


Fig. 5 Flush abdominal aortogram in a 47-year-old woman shows the typial picture of fibromuscular hyperplasia of the right renal artery. This characteristically is seen in the middle and distal thirds of the renal artery. This patient has been normotensive following right aortorenal bypass procedure.

artery stenosis. There is inherent in these screening tests a 20% incidence of false negative results. In light of this fact, any good risk patient who has significant hypertension which is impossible to adequately maintain in the range of 140/90 or below should have an aortogram. This is recommended in spite of a normal finding in an IVP or renogram and is especially pertinent to the young and middle-aged patient in whom the threat of uncontrolled hypertension far outweighs the negligible risk of renal arteriography. The potential for cure or improvement is great if a sugically corectable lesion is found.

Renal artery stenosis is caused by either atherosclerosis or fibromuscular hyperplasia in the vast majority of cases. Atherosclerosis usually occurs in an older age group than fibromuscular hyperplasia and is more likely to occur in men, while fibromuscular hyperplasia is more commonly seen in women. Atherosclerosis usually involves the proximal third of the renal artery and is best seen on the flush aortogram (Fig. 4). Fibromuscular hyperplasia more commonly involves the middle and distal thirds of the renal artery (Fig. 5). These lesions often are demonstrated better with selective renal arteriography with the patient in an oblique position (Fig. 6).

The demonstration of a stenotic renal artery in a hypertensive patient does not necessarily indicate a casual relationship. Stenotic renal arteries are seen often in the course of aortography in patients who are normotensive. Early efforts at reconstruction of all stenotic lesions of the renal artery in hypertensive patients was met with disappointing results. The current practice of determining the functional significance of such lesions has yielded encouragingly good results. Foster[3] has reported a 95% incidence of cure or significant improvement in control of the hypertension with renal artery

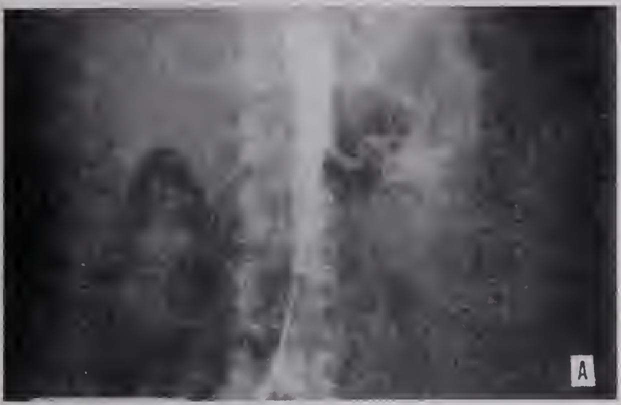
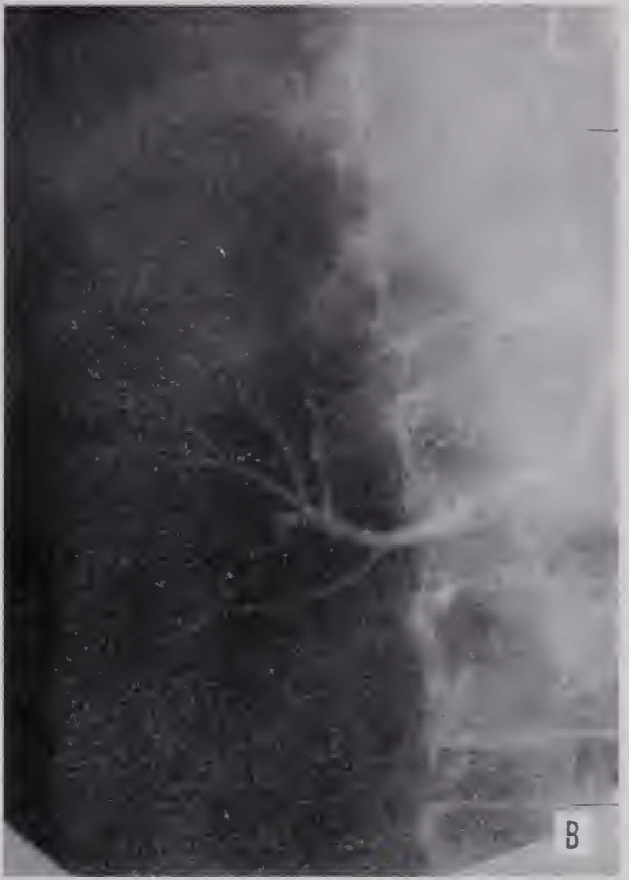
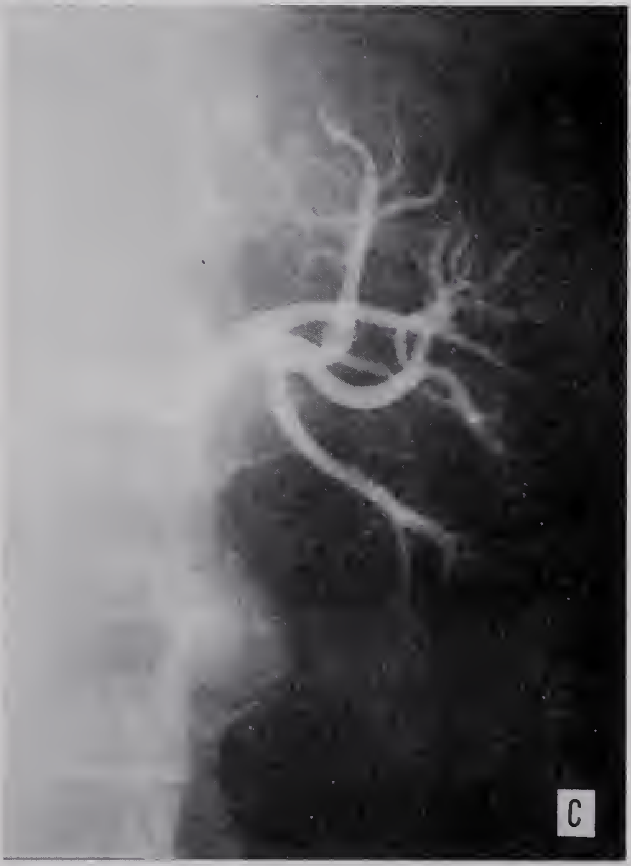


Fig. 6 (A) Flush abdominal aortogram of a 38-year-old woman was done at an earlier date and was inadequate to fully evaluate renal artery disease. The patient subsequently was treated with antihypertensive drugs but with inadequate control of hypertension. She recently was admitted for evaluation and thorough arteriographic examination of the renal arteries which included selective injection of both renal arteries in oblique positions (B, C). Selective injection of the renal arteries eliminates overlying mesenteric vasculature and gives better detail evaluation of the extent of the disease. The oblique position allows visualization of the renal artery in its largest axis and may clearly show lesions in the middle and distal thirds of the renal arteries which are not seen on flush abdominal aortography (B, C). These steps are essential in the evaluation of fibromuscular hyperplasia as is evidenced in this series of x-rays (A, B and C.)→





reconstructive surgery when patients were selected on the basis of functional significance. Results of this type cannot be expected without the use of differential renal venous renin assay or split renal function tests, or both, to establish the functional significance of a stenotic renal artery in a hypertensive patient.

Radioimmunoassay of the enzyme renin which is secreted by the juxtaglomerular apparatus of the kidney provides the basis for the most widely used test of functional significance of renal artery stenosis. Blood samples are obtained from the renal vein of each kidney with a catheter introduced into the femoral vein. The functional significance of a stenotic renal artery is determined by the ratio of renin concentrations in the venous blood from each kidney. There must be a 50% to 75% increase in renin concentration on the involved side before renal artery reconstruction can be considered.[4] The quantitative level of renin concentration is of little significance except in those patients with bilateral renal artery stenosis.

Howard[5] and Stamey[6] tests also may be used to determine the significance of renal artery stenosis. These tests are based on the fact that the involved kidney will excrete a reduced volume of water and reduced concentration of sodium and an increased

(Continued on page 653)

RALPH M. NEIGHBOR, M.D., ROBERT L. NEWMAN, M.D.
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Perinatal Mortality in Toxemia

CLINICAL MATERIAL

PERINATAL MORTALITY in toxemia is considered in this study on the basis of data accumulated from all deliveries at St. Luke's Hospital of Kansas City over the ten-year period from January, 1962 through December, 1971. In this ten-year period, there were 21,211 deliveries yielding 21,469 infants. Of these infants, 857 were born of mothers in the toxemia group yielding an incidence of toxemia in our hospital of 4.0%. In this group, there were 45 perinatal deaths yielding an incidence of 5.3%. It is the purpose of this presentation to analyze these deaths and the circumstances under which they occurred. In this presentation, the term toxemia is synonymous with preeclampsia-eclampsia.

ANALYSIS OF DATA

Comparing the First and Second Five-Year Periods (Tables 1 and 2)

Throughout this presentation, the perinatal deaths will be considered in four groups: neonatal deaths, fetal death before admission, fetal death after admission and postneonatal deaths. By studying the first and second five-year periods separately, it is hoped that improvements in therapy as reflected by greater perinatal salvage may be elucidated.

In the period from 1962 through 1966, there were 10,418 pregnancies yielding 10,536 infants. There were 431 infants born of toxemic mothers with 27 perinatal deaths or an incidence of toxemia of 4.1% with perinatal mortality occurring in 6.3% of these cases. Considering the period from 1967 through 1971, one finds 10,803 pregnancies yielding 10,933 infants. In this period, 426 infants were born of toxemic mothers with 18 perinatal deaths or an incidence of toxemia of 3.9% with perinatal mortality occurring in 4.2% of these cases. Thus, one finds a decrease in perinatal mortality of 2.1%.

The purpose of this study is to analyze 45 cases of perinatal mortality associated with toxemia which occurred in a ten-year period from 1962 through 1971. The data are divided into the first and second five-year periods for comparison and show a marked decrease in neonatal deaths but no improvement in preventing fetal deaths before hospital admission. The lack of standardization of therapy for toxemia is explored and the need for such standardization is emphasized. The authors are from the Department of Obstetrics and Gynecology, St. Luke's Hospital.

Neonatal deaths in the first five years numbered 14, yet there was but one in the second five years. This is a marked improvement since it can be seen that once born, an infant's chance of survival was 14 times greater in the second five years than in the first. This success cannot be claimed by the obstetrician, however, since this increased survival corresponds to advances in nursery technique and greater understanding of neonatology by the pediatricians.

The two categories for which the obstetrician has sole responsibility have not seen such improvement. In fact, one finds an increase of 1% in fetal deaths before admission. There were seven cases of fetal death before admission in the first five years and 11 in the second, corresponding to percentages of 1.6 and 2.6, respectively. Fetal death occurring after admission has seen a slight increase; five cases having occurred in the first five years and six having occurred in the second five years. This represents an increase of 0.2% from 1.2% to 1.4%. Thus, it can be stated that obstetrical care has not altered fetal death rates in any favorable fashion in the ten years under study.

There was but one postneonatal death, which occurred in the first five years.

Comparing the Clinic and Private Services (Table 3)

Of the 857 births from toxemic mothers, 203 were patients of the Residents' Clinic and 654 were patients of private physicians. Fifteen deaths occurred in the clinic group and 30 in the private group, yielding percentages of 7 and 4.5, respectively.

Three neonatal deaths occurred on the clinic service and 12 on the private service or 1.5% versus 1.8%. Six fetal deaths before admission occurred on the clinic service (3%) and 12 occurred on the private service (1.8%). Fetal deaths after admission occurred in five cases on the clinic service (2.5%) and six cases on the private service (.9%). The one postneonatal death occurred in a clinic patient.

TABLE 1

TOXEMIA—INFANT MORTALITY
1962-1966

Year	*Disc. Alive*	*Neonatal Deaths*	*Fetal Deaths* B/F ADM.	AFTER	*Post-Neonatal Deaths*	*Total Deaths*	*Total All Infants*	*Total Preg.*	*Total Infants*
1962	98	4	1	1		6	104	2,369	2,393
1963	94	4	1			5	99	2,162	2,188
1964	72	4	2	1	1	8	80	1,997	2,016
1965	68		2	2		4	72	1,912	1,942
1966	72	2	1	1		4	76	1,978	1,997
Total	402	14	7	5	1	27	431	10,418	10,536
%	93.7	3.3	1.6	1.2	0.2	6.3	100		4.1

TABLE 2

TOXEMIA—INFANT MORTALITY

1967-1971

Year	*Disc. Alive*	*Neonatal Deaths*	*Fetal Deaths* B/F ADM.	AFTER	*Post-Neonatal Deaths*	*Total Deaths*	*Total All Infants*	*Total Preg.*	*Total Infants*
1967	55		3	2	0	5	60	1,861	1,878
1968	116		2	1	0	3	119	1,953	1,979
1969	89		2		0	2	91	2,180	2,198
1970	98		1		0	1	99	2,358	2,403
1971	50	1	3	3	0	7	57	2,451	2,475
Total	408	1	11	6	0	18	426	10,803	10,933
%	95.8	0.2	2.6	1.4	0.0	4.2	100		3.9

TABLE 3

COMPARISON OF CLINIC AND PRIVATE SERVICES

Service	*Discharged Alive*	*Neonatal Deaths*	*Fetal Deaths Before Admission*	*Fetal Deaths After Admission*	*Post-Neonatal Deaths*	*Total Deaths*	*Total All Infants*
Clinic	188	3	6	5	1	15	203
% of total	93	1.5	3	2.5	.5	7	100
Private	624	12	12	6	0	30	654
% of total	95.5	1.8	1.8	.9	0	4.5	100
Total	812	15	18	11	1	45	857
%	94.7	1.75	2.1	1.3	.12	5.3	100

Severity of Toxemia (Table 4)

The well-known classification of preeclampsia-eclampsia is portrayed in Fig. 1. In the ten-year period, there were 55 cases of eclampsia, with four perinatal deaths occurring in this group.[1] All four of these patients had antepartum convulsions, there being one neonatal death and three fetal deaths after admission. Twenty-seven deaths occurred in parturients with mild preeclampsia, and 14 occurred in the severe group.

Reproductive History of the Parturient (Table 5)

In considering the reproductive histories of the mothers, one finds eight primipara under 20 years of age, 13 primipara ages 20 through 30 years and two primipara greater than 30 years of age. The remaining 22 deaths occurred in infants born of multipara.

MANNER AND MODE OF DELIVERY (Table 6)

Spontaneous labor occurred in 24 (53%) of patients in the study group, with oxytocin augmentation being required in 14 (31%). Oxytocin induction of labor was used in 19 (45%) patients and Caesarian section was resorted to twice (4.4%).

Modes of Therapy (Table 7)

The currently expounded therapy of choice for preeclampsia-eclampsia consists of bedrest[2] and

TABLE 4

SEVERITY OF TOXEMIA

Category	*Pre-Eclampsia* MILD	SEVERE	*Eclampsia*	*Total*
Neonatal deaths	10	4	1	15
Deaths before admission	11	7	0	18
Deaths after admission	5	3	3	11
Post-neonatal deaths	1	0	0	1
Total	27	14	4	45

TABLE 5

REPRODUCTIVE HISTORY OF PARTURIENT

Category	*Primapara <20 y/o*	*Primapara 20 thru 30 y/o*	*Primapara <30 y/o*	*Multipara*
Neonatal death	1	5		9
Fetal death before admission	3	5	1	9
Fetal death after admission	3	3	1	4
Post-neonatal deaths	1	0		0
Total	8	13	2	22

TABLE 6

MANNER AND MODE OF DELIVERY

Category	*Spontaneous Labor*	*Augmented*	*Induced*	*C-Section*	*Total*
Neonatal deaths	5	3	6	1	15
Fetal death before admission	3	5	9	1	18
Fetal death after admission	1	6	4	0	11
Post-neonatal death	1	0	0	0	1
All deaths	10	14	19	2	45

liberal usage of magnesium sulphate to control or prevent convulsions.[3-4] The cure of this disease is believed to be accomplished with delivery of the placenta. Use of diuretics is currently in disrepute, and the efficacy of salt restriction is currently being questioned by some.[5] Of the 43 parturients, only 12 received magnesium sulphate during their hospitalization. Eighteen received diuretics and 13 received antihypertensive medications. Barbiturates were administered to 27 patients, and 42 received narcotics during labor. Two of the eclamptics received diphenylhydantoin.

Birth Weights (Table 8)

There were two twin births in the study group. Nineteen of the infants weighed less than 1,500 gm, ten weighed between 1,500 gm and 2,500 gm and 16 weighed more than 2,500 gm.

CLASSIFICATION OF TOXEMIA

Mild Pre-Eclampsia	*Severe Pre-Eclampsia*	*Eclampsia*
140 systolic or 30 mm Hg normal 90 diastolic or 15 mm Hg normal 6 hrs apart at bedrest	160 systolic 110 diastolic 6 hrs apart at bedrest	Convulsions and/or Coma
Significant proteinuria on two occasions	Proteinuria 5 g/24 hrs Oliguria 400 ml/24 hrs	
Oedema of hands and face	Cerebral or Visual Disturbances	
	Pulmonary Oedema or Cyanosis	
	Any one of the above	

Fig. 1

COMMENT AND CONCLUSIONS

It would seem clear from the comparison of the first and second five-year periods that while the pediatricians have made great strides in the salvage of infants born of toxemic mothers, the obstetricians have had no success in reducing the antepartum death rates in this group. Fetal deaths after admission are tragic and, with current developments, should be largely preventable. It would appear that fetal deaths before admission could also be reduced.

Of primary importance is early recognition of those patients at risk,[6] close monitoring with currently available studies and more frequent office visits. Serial estriol determinations are indispensable in monitoring the high-risk obstetrical patient. Lecithin/sphingomyelin ratios also have become of great value to the obstetrician in determining the relative risks of intrauterine versus extrauterine life. Fetal monitoring certainly is indicated in all toxemic patients in labor. Although these aids are used frequently, their use is not yet universal.

As well, there should be some standardization of therapy. Magnesium sulphate, the drug of choice in toxemia,[7-9] was used in only 36% of the patients in this study group, and many drugs of no proven value were used with much greater frequency.

The failure to reduce intrauterine death in toxemic patients is indeed alarming. It will be necessary to evaluate our approach to this disease and scrutinize our current practices. Through this process, a greater fetal salvage rate probably would result.

TABLE 7
MODES OF THERAPY

Categories	*# of Cases*	*Other Analeptics*	*$MgSO_4$*	*Diuretics*	*Antihypertensives*	*Barbiturates*	*Narcotics*
Neonatal deaths	15	0	2	9	7	10	13
Fetal death B/F admission	18	0	6	4	3	12	18
Fetal death after admission	11	2	4	4	3	5	9
Post-neonatal deaths	1	0	0	1	0	0	1
All deaths	45	2	12	18	13	27	42

TABLE 8
BIRTH WEIGHT IN GRAMS

Category	*Multiple Birth*	*500 gm or Less*	*500-1000*	*1001-1500*	*1501-2000*	*2001-2500*	*2501-3000*	*3001-3500*	*3501-4000*	*Total*
Neonatal death	4	2	3	3	2	2	0	2	1	15
Death before admission	0	0	4	4	2	2	5	1	0	18
Death after admission	0	2	0	1	1	1	6	0	0	11
Post-neonatal death	0	0	0	0	0	0	1	0	0	1
Total	4	4	7	8	5	5	12	3	1	45

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Hypertension Revisited

(Continued from page 649)

concentration of fixed solutes, such as creatinine and PAH when this is given. The test requires selective catheterization of each ureter with timed collection of urine from a well-hydrated patient. Split renal function tests done in this manner have a high degree of accuracy in selecting patients for surgical treatment of renovascular hypertension. The principal disadvantage of this procedure is the morbidity associated with ureteral catheterization. Though this is minimal, it is significantly greater than with renal venous renin determinations. Split renal function tests are reserved for use in those cases when renin determinations are equivocal and in bilateral renal artery stenosis.

Unilateral renal atrophy, whether related to vascular or parenchymal disease, may be etiologic in hypertensive patients. Functional significance should be established, if possible, with renal vein renin determination or split renal function tests. Nephrectomy should be considered when the renal mass is too small to warrant arterial reconstruction or when the etiology is unilateral parenchymal disease.

Bilateral parenchymal disease resulting in chronic renal failure is often associated with uncontrollable hypertension. When dietary control of chronic renal failure and antihypertensive drug therapy fail to control the hypertension, chronic hemodialysis and bilateral nephrectomy will be required in patients with moderate and severe hypertension. Renal transplantation will potentially be applicable to this group of patients.

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FERNANDO J. deCASTRO, M.D., ***St. Louis***

Oral Decongestant in Acute Otitis Media: A Single Blind Trial

Therapy for acute otitis media is still controversial. Although there is reasonable consensus of opinion regarding bacterial etiology,[1-12] studies of the value of oral decongestant (vasoconstrictor-antihistaminic combination) together with antibiotics are few and conflicting.

The value of a vasoconstrictor agent used together with antibiotics in the treatment of otitis media has been seriously questioned.[13] On the other hand, the value of antihistaminic administration together with antibiotics has been said to be beneficial.[14]

The present study was designed to evaluate the relative effectiveness of an antihistaminic-vasoconstrictor combination together with antibiotics in the treatment of acute otitis media.

Material and Methods

Criteria for admission to the study were as follows: (a) clinical evidence of acute otitis media as judged by a pediatrician (staff pediatrician or house staff); (b) zero to 16 years of age regardless of sex or race; (c) no evidence of penicillin allergy, vomiting, mastoiditis or chronic suppurative otitis media; and (d) ability to have a final evaluation visit in ten days (44/244, i.e., 20% of the patients were eliminated from the study because of failure to keep their final evaluation visit appointment. These patients belong to the same population as the rest of the studied patients regarding sex, age and therapy).

The 200 patients studied were all given ampicillin if they were below three years of age and penicillin if they were three years or older. They were then randomly divided into two groups: 100 experimental and 100 control, matched for age and sex. The control group received only antibiotic. The experimental group received both antibiotic and an oral decongestant (vasoconstrictor-antihistaminic combination). Actifed® tablets containing 2.5 mg of tripolidine hydrochloride and 60 mg of pseudoephedrine hydrochloride or Actifed® syrup containing half of the above amounts per teaspoon were used. The dose schedule was as follows: ½ teaspoon three times a day for children below four months old; one teaspoon three times a day for children four months to six years of age and one teaspoon four times a day or one tablet three times a day for children older than six years old.

TABLE 1

AGE AND SEX DISTRIBUTION OF THE EXPERIMENTAL AND CONTROL GROUPS

		Control		*Experimental*	
Group	*Age in Years*	MALE	FEMALE	MALE	FEMALE
1	0-3	18	20	20	19
2	4-7	15	22	17	16
3	8 & older	11	14	18	10
Totals		44	56	55	45

Patients were asked to return in 48 to 72 hours if they had no symptomatic relief. All patients also were asked to return in ten days for their final evaluation. At that time, they were examined without knowledge of the type of treatment for the presence of persistent otitis media (purulent or serous).

The following criteria were used to determine persistence of otitis media (purulent or serous): (a) otorrhea, (b) redness of the tympanic membrane not associated with crying, (c) distortion of light reflex, (d) fluid level or bubbles and (e) perforation of the tympanic membrane. No serious purulent complications such as mastoiditis or meningitis were encountered during the study.

Results

The mean age for the experimental group was 5.5 years and for the control group 5.9 years. The age and sex distribution in both "experimental" and "control" groups are shown in Table 1. There is an apparent predominance of boys over girls in the experimental group as compared to the control group. However, this apparent difference may occur by chance ($p > 0.05$).

Table 2 shows the main results of the study. In the "experimental group," i.e., those patients receiv-

TABLE 2

THERAPEUTIC SUCCESSES AND FAILURES IN BOTH EXPERIMENTAL AND CONTROL GROUPS

Group	*Failure*	*Successes*	*Total*
Experimental	30	70	100
Control	49	51	100

ing antibiotic plus oral vasoconstrictor-antihistaminic agent, the failure rate evidenced by lack of complete resolution of otitis media at the end of nine to 11 days was 30%. The failure rate in the "control group" was 49%. Chi square analysis reveals that this difference is statistically significant ($p < 0.01$).

Discussion

Acute otitis media is a common complication of acute upper respiratory infection. Its etiology and treatment have been widely investigated in numerous bacterologic[1-12] and chemotherapeutic studies.[12-16] Although these studies are controversial regarding their specific findings, there is ample evidence that antibiotics should be used in the treatment of acute otitis media. Antibiotics have decreased the evidence of purulent complications of acute otitis media (mastoiditis, chronic purulent otitis media and others). The antibiotics used in the present study were chosen in order to provide coverage for the most likely bacterial pathogens for the specific age group (see method). No purulent complications of acute otitis media occurred in either control or experimental group.

Although antibiotics have decreased the incidence of several complications of acute otitis media, there is an increasing awareness of the relationship between acute otitis media and chronic serous otitis media associated with hearing loss.[16] Opinions regarding the value of myringotomies in acute otitis media in order to prevent serous otitis media are contradictory. Some investigators recommend the use of myringotomies[17] while others deny their effectiveness.[12, 14, 16] In the present study, no myringotomies were performed.

In attempting to prevent chronic serous otitis as a complication of acute otitis media, additional therapeutic agents are widely used in the treatment of acute otitis media without definite documentation of their value. One large study seriously questioned the value of oral vasoconstrictor-antihistaminic agents in addition to antibiotics in acute otitis media.[13] Another large study suggests the value of oral antihistaminic together with antibiotics in acute otitis media.[14]

In the present study, we attempted to determine the value of the oral vasoconstrictor-antihistaminic combination in addition to antibiotic in acute otitis media.[4]

Our findings (see Results) show that there was a 30% cure failure rate when antibiotics and oral decongestant were used and 49% cure failure rate when only antibiotics were used. This difference is statistically significant ($p < 0.01$) and suggests the usefulness of oral decongestants in the treatment of acute otitis media.

The etiology and treatment of acute otitis media have been widely investigated in numerous bacterologic and chemotherapeutic studies. This study was designed to evaluate the relative effectiveness of an antihistaminic-vasoconstrictor combination together with antibiotics in the treatment of this complication. The author is from the St. Louis University-Cardinal Glennon Hospital.

Although the treatment failure or cure failure rate of 30% and 49% in the "experimental" and "control" groups at the end of ten days may appear high, it is probably due to strict criteria for cure. The cure rates of the present study are comparable to a previous study in which similar strict criteria were used to diagnose resolution of otitis media.[12]

Purulent complications of acute otitis media have decreased greatly. However, serous otitis media is found in spite of the use of antibiotics. The present study was designed to determine whether or not oral decongestant (vasoconstrictor-antihistaminic combination) used together with antibiotic in the treatment of acute otitis media decreases the incidence of chronic serous otitis media secondary to acute otitis media. The use of oral decongestant together with antibiotic in the treatment of acute otitis media, therefore, is recommended.

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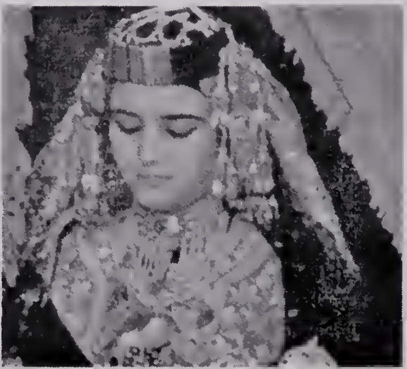

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President's Message

At this writing, I have just returned from a week in Washington, D. C. and am deeply concerned about the atmosphere in our nation's capitol.

I heard a government economist state, "There will be no tears when doctors' incomes are reduced." I heard Dr. Simmons of the Department of Health, Education and Welfare say, "We can use PSROs to bring research to the patient . . . for example, the recent advances in breast surgery for cancer."

James C. Cope, M.D.

National Health Insurance appears to be assured of passage in the 1975 Congress.

I feel an undercurrent of vindictiveness toward the private sector of those supplying medical care.

Physicians need two things immediately: A strong voice and political clout.

I strongly recommend that the following action be taken immediately by every physician:

Join the AMA and let the AMA speak for us. At this moment, there are more AMA members than ever before. The previous high was in 1970 with 168,214 members. As of Oct. 4, 1974, there were 168,737 members—the highest on record. To be effective, we must speak with one voice.

We need more legislative clout. AMPAC elected 80% of its candidates in this year's primaries. If you do not belong to AMPAC and MMPAC, you should join.* Send $25 for a participating membership, $40 for a family membership or $100 for a sustaining membership to the MSMA Headquarters Office. DO IT NOW. The Congress elected this fall is the one that will shape National Health Insurance and our profession for the foreseeable future.

The hour is late, the outcome is of the highest importance.

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* A copy of MMPAC report filed with the appropriate supervisory office is (or will be) available for purchase from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402.

Woman's Auxiliary

50th Anniversary

November's sky is chill and drear,
November's leaf is red and sear.
—Scott

Dreary and chilly skies do not reflect the warmth in the hearts of all Americans as we pause each November to give thanks. MSMA Auxiliary members have many reasons to be thankful.

Mrs. George J. Lytton
President

Members in practically every county in the state feel a warm glow from the realization that many nurses finish training with the help of scholarships given by the Woman's Auxiliary. Many auxiliaries can feel thankful for their accomplishments in aiding medical students through funds raised for the American Medical Association Education Research Foundation and for the Missouri State Medical Foundation.

Community service by participation in "Meals on Wheels," well-baby clinics, babysitting training and blood donor programs is another expression of gratitude on the part of Auxiliary members. Promotion of health careers by funneling young people into the various aspects of medicine is another item which gives our members a feeling of gratitude. Health Career Fairs, films donated to schools and catalogues of available jobs are examples of the forms of these promotions.

Auxiliary members also are thankful to be living in a country in which our democratic form of government can be supported by all. Legislative committees in each auxiliary educate the members and keep them informed of the latest developments in legislation.

Thanksgiving is in the hearts of all Auxiliary members because we belong to a worthwhile organization which, at the same time, enhances the image of our physician husbands.

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

Forty-two physicians heard an outstanding presentation on "The Diagnosis and Treatment of Rheumatoid Arthritis" by Dr. Paul D. Saville at the October meeting of the Society.

Dr. Saville is chief of rheumatology at the University of West Virginia in Morgantown. Prior to going to Morgantown this fall, he was professor of medicine and chief of the Department of Rheumatic Diseases at Creighton University in Omaha.

Dr. Robert F. Tobin, who was a pupil of Dr. Saville's, introduced the Speaker.

In a business meeting which preceded the program, the Society voted to support a bond issue to provide a new classroom building for Missouri Western State College in St. Joseph.

Dr. Randal W. Weed, President, presided at the meeting. Arrangements for the dinner, meeting and program were made by the Society's program committee which includes Dr. Edward M. Beheler, chairman, and Drs. Robert R. Stuber and Edward H. Andres.

John T. Rogers, M.D., *Secretary*

Continuing Education Coming Events

Nov. 19	**Gastrointestinal CPC With Medical and Surgical Overtones** N.W. Mo. Chapter, Mo. Academy of Family Physicians and K.U. School of Medicine Moila Temple, St. Joseph
Nov. 22-23	**15th Annual M.D. Day** Continuing Medical Education M.U. Medical Center, Columbia
Nov. 22-23	**The Long Weekend: Neurology and Psychiatry** M.U.-K.C. School of Medicine and Division of Continuing Education, K.C. Southwest Clinical Society and the Academy of Health Professions Crown Center Hotel, Kansas City
Dec. 4	**Seminar: Current Concepts of Antibiotic Therapy** The Ed Bixby Institute for Postgraduate Medical Education Research Hospital and Medical Center Kansas City
Dec. 7	**Chromosomes and Sex Chromatin** Continuing Medical Education M.U. Medical Center, Columbia
Dec. 9-10	**Symposium: The Battered Child** Postgraduate Education K.U. Medical Center, Kansas City, Kan.
Dec. 12-13	**Annual Clinical Meeting** Kansas City Society of Ophthalmology and Otolaryngology Plaza Inn, Kansas City
Dec. 12-14	**The Heart—1974: Current Topics of Cardiology** Continuing Medical Education MU-KC School of Medicine Crown Center Hotel, Kansas City

The Council Reports

(Continued from page 643)

so was recommended that this be printed in a manner suitable for mailing to the individual physician rather than including it in an issue of Missouri Medicine.

The Committee discussed the possible use of computer services for dues billing, dues accounting, monthly reports, membership maintenance, roster and typesetting for directories and services and recording of CME credits. It was felt that computer services could be of great advantage for MSMA, and staff was directed to develop proposals on this service for further consideration.

The Committee directed staff to contact the local telephone company to conduct a feasibility study regarding an inward and/or outward WATS line for the Association.

Discussion by the Committee was held regarding Association Vice-Presidents. It was felt that the present position of Association Vice-President is mostly an honorary designation. It was suggested that possibly they should be invited to Council Meetings and be utilized by the President in attending meetings as his designee and/or being assigned by the President as ex officio members of certain committees and commissions of the Association.

The Planning Committee requests that the MSMA president-Elect, shortly after his election, meet with this committee to discuss his proposed program for his year as President. Perhaps they can be of assistance in helping him accomplish some of his objectives.

On motion, duly seconded, the Council recommended acceptance of the Report of the Committee on Planning. Motion carried.

REPORT OF THE COMMISSION ON INTERSPECIALTY MEDICINE, CME AND HEALTH MANPOWER

Dr. McCanse gave a brief rundown on the activities of these two commissions and indicated that this is only an interim report.

The Councilor District representatives went over the continuing medical education plan proposed for the MSMA members. This plan is voluntary. The responsibilities of the district representatives were outlined. It was pointed out that in order for continuing medical education to be effective, it will have to be done mostly in a local setting, such as in hospitals. Mr. Ellison indicated that he visited the AMA office in Chicago and received assistance on what type of certification CME proposal might be the best for Missouri. He received one proposal which he felt, with a few modifications, would fit the Missouri situation. A subcommittee has been appointed to go over this proposal and make the necessary additions, deletions, etc. This subcommittee will report back to the full Committee and then to the MSMA Council.

The Ad Hoc Committee for the 117th Annual Session developed the basic policy for reimbursement of expenses and honorarium to speakers during MSMA Annual Sessions. The one general session at the upcoming annual meeting will have a topic of National Health Insurance and speakers on this topic are now being sought.

Mr. Ellison asked that the Councilors inform the MSMA office as soon as they have decided on what food functions they will need for their Councilor District during Annual Session.

COMMITTEE ON ARRANGEMENTS

Dr. Franklin appointed the following members to the Committee on Arrangements for the 117th Annual Session: Max S. Franklin, M.D., Chairman; Louis P. Hetlage, M.D., and Howard J. McAlhany, M.D., Co-Chairmen.

REPORT OF MSMA WOMAN'S AUXILIARY

Mrs. Lytton introduced Mrs. Mary Kay McPhee, President-Elect of the MSMA Woman's Auxiliary, to the Council. The Fall Conference of the MSMA Woman's Auxiliary will be held October 23-24. The President and President-Elect will attend a National Leadership Training Seminar in Chicago during October. Also, there will be a North Central Regional Workshop in Chicago in October.

The Environmental Protection Agency has asked to present a part of the Fall Conference and is also asking the Auxiliary to appoint a county EPA official. These appointees will be asked to attend a seminar on solid waste. Funds are available for these programs to be developed.

Mrs. Lytton reported that the Medical Assistants group has asked to assist the Auxiliary with legislation and indicated that she was seeking MSMA approval for this. It was pointed out that certainly any assistance they could receive would probably be helpful when properly directed.

REPORT OF AMA DELEGATES

Dr. Washburn reported that a summary of events of the 1974 AMA Annual Convention has been published in the *Journal*. However, he listed some of the highpoints.

First, of course, the AMA's stand on PSRO was channeled in the direction of "seeking constructive amendments" to the present law. The new stand does allow room for those states which have voted nonparticipation and concludes by stating that if PSRO proves to adversely affect patient care, the AMA will use all legal and legislative means to rectify the problems.

The previous AMA stand adopted in Anaheim called simultaneously for active leadership in implementation, amendment of the law and finally, repeal of the law. It definitely needed to be changed. Although debate was hot and heavy in the Reference Committee, when PSRO reached the House, an early call for a vote was passed and the new policy was adopted overwhelmingly.

Following the anti-climax over PSRO, the election of Officers and Trustees *did* provide major changes and, perhaps, surprises.

The House changed the method for selecting Trustees from "slot" elections to "simultaneous" elections, thus pitting all 11 candidates against each other for the six open positions on the Board.

In a lengthy election process, only one of three incumbents, Ray Holden, was returned to the Board. Also, Max Parrott, newly elected AMA President-Elect, narrowly held off a last minute campaign by Dick Wilbur to win the post by two votes. Obviously, the articles published in *Medical World News* concerning internal affairs of the AMA had an impact on the elections.

Other items of interest include the successful reelection bid of Dr. Joe White to the Council on Medical Education and the referral of Missouri's resolution concerning "Coordination of AMA-ERF Fund Recipients and Practicing Physicians," which was lauded for its intent and referred to the AMA-ERF Board for study and recommendation.

As I am sure you are aware, there are a lot of important activities carried out at AMA Conventions besides the Sessions of the House. Reference Committees must be attended and reported on, caucuses must be held (usually very early in the mornings) to discuss our stands, satellite meetings on a variety of important subjects must be manned, someone must set up a schedule and escort our candidates around to meet other delegations and, of course, all of us must act a hosts during our hospitality gatherings.

Therefore, the Delegation would like to thank those people who expended their time and energy in our behalf and your behalf at the Convention.

Regarding our hospitality room there is a possibility that due to limited space at the Portland Hotel, we will combine with Kansas, Arkansas and Oklahoma to sponsor one "open house." However, we will have our own meeting room.

REPORT OF THE COMMITTEE ON LEGISLATIVE AFFAIRS

Dr. Matthews reported that four counties have now adopted the medical examiner system. The interim committee of the Legislature that is to study acupuncture, physician assistants, surgicenters and medical laboratories has not met, but it will probably have hearings after the general election in November.

Dr. Matthews stated that the Council had established a policy that acupuncture was the practice of medicine. Such a policy also was adopted by the Board of Healing Arts. Dr. Matthews stated that MSMA should reaffirm our position on acupuncture. The Board of Healing Arts should be asked to reaffirm its policy and, possibly, consider promulgating guidelines, rules and regulations regarding acupuncture and also ask for an Attorney General's position regarding this.

It was moved, seconded and carried that the MSMA ask the Board of Healing Arts to reaffirm its position on acupuncture and possibly consider promulgating guidelines, rules and regulations on acupuncture and ask the Attorney General for his opinion regarding this position.

Dr. Matthews stated that the National Board of Medical Examiners is developing guidelines for the registration of physicians assistants. He stated that at present, perhaps our position should be to go along with the National Board of Medical Examiners registration of physicians assistants and that licensing of assistants be deferred.

Dr. Matthews reported that a surgicenter bill is ready and is going to be prefiled. This bill will establish surgicenters in Missouri. The bill will be supported by the Association on the basis of previous endorsement of this principle.

A bill calling for licensing of medical laboratories was introduced in the last session of the General Assembly, but did not pass. Regulations of the conditions for coverage of services for independent laboratories appearing in the *Federal Register* in July are nearly identical to the medical laboratory bill introduced last session. Any bill introduced and adopted by the Legislature would have to comply with federal laws and, perhaps, it would be better to wait a year or two and then pass legislation that would conform with federal requirements.

Dr. Matthews indicated that a report from the Committee on Midwifery had been adopted at the April 3 meeting of the Council. An Attorney General's opinion was issued in 1972 regarding this. The Attorney General's opinion indicated that midwifery is the practice of medicine and the medical practice act would have to be changed in order to provide for nurse-midwives. Dr. Matthews stated that at this point he felt that this matter should be referred back to the Committee on Midwifery for further study.

Dr. Matthews stated that several resolutions were passed during the last session of the House of Delegates which called for legislation on several items. These are Resolution #2—Mandatory Seat Belt Law; Resolution #23—Insurance Coverage for Mental Illness; and Resolution #31—Complete Maternity Coverage under Health and Accident Policies. Legislation will be introduced on all these subjects. The House of Delegates also adopted Resolution #24 which calls for support for legislation introduced to discourage driving while intoxicated.

Dr. Matthews stated that a bill may be introduced that calls for the authorization under the Uniform Anatomical Gift Act to be printed on the reverse side of Missouri motor vehicle operators and chauffeurs licenses.

Dr. Matthews stated that several legislators have asked if we would like for them to introduce good samaritan legislation because of the Attorney General's opinion that it was not properly enacted through passage of the ambulance bill.

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Legislation may be introduced proposing a change in the Missouri two-year statute of limitations.

It was moved, seconded and carried that this report be accepted.

REMARKS OF THE CHAIRMAN, BOARD OF REGISTRATION FOR THE HEALING ARTS

Dr. James Brown, newly appointed Chairman of the State Board of Registration for the Healing Arts, said that he would be happy to relay any messages that the Council wished to send to the State Board.

Dr. Brown said that the major problem facing the Board is the influx of foreign medical graduates. At the time it was ruled that citizenship was not a factor for licensing of doctors in Missouri, it was felt that the Board's examination was not difficult enough and so two years ago, the Board switched to the FLEX examination. Medical Schools in the state are now utilizing the National Board examinations and by the time a student has graduated from medical school, he has completed two parts of the three-part national board examination, and usually completes the third upon graduation. Thus, most of those taking the FLEX examination from the Board of Healing Arts are foreign medical graduates. Because of this, the State Board of Registration for the Healing Arts feels that some changes need to be made in the state licensing law.

Dr. Brown stated that he didn't feel that the State Board could be of much help in the acupuncture situation. He indicated that the problem would be how do you license someone for a particular specialty when no guidelines of education have been set up and there are no schools in the country that teach it.

Dr. Cope said that the Legislative Committee wanted the Board of Healing Arts to reaffirm its previous statement that acupuncture is the practice of medicine and ask for an Attorney General's opinion favorable to that statement.

Dr. Brown indicated that the Board of Healing Arts had not done anything with the physician assistant problem because there is no consensus of education from state to state in regard to registration or licensing for these people.

Dr. Matthews said that the Legislative Committee would like for the Board of Registration for the Healing Arts to recognize the National Board of Medical Examiners examination covering certification of medical assistants and then promulgate rules and regulations on how they will be certified in Missouri.

MSMA TRAVEL COMMITTEE

Dr. Cooper stated that the Travel Committee recommends the following two trips for 1975: a 14-day trip to Africa in February of 1975 and a trip to Canada and Alaska in August or September, 1975.

It was moved, seconded and carried to sponsor these two trips.

Mr. Al Lerner, new Field Representative from the AMA, brought the Council up to date on NHI. He stated that because of the large number of health oriented bills in Congress and state legislatures, the AMA has set up a program called "Action 74" and is urging each state to form an ad hoc committee that will have expertise on this type of legislation. The AMA will provide information and assistance to these committees in dealing with health legislation in the state.

Mr. Cooper reported that the master contract for our new major medical insurance program had been approved, the brochure also approved and a mailing for this new insurance program should be sent out shortly. Our new group term life insurance program should be ready for mailing in November or December.

NEXT COUNCIL MEETING

The next meeting of the Council will be held on December 14 at the Ramada Inn in Jefferson City. The Budget Committee will meet at 2 PM at the Ramada Inn on Friday, December 13.

The meeting was adjourned.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (ACT OF AUGUST 12, 1970: SECTION 3685, TITLE 39, UNITED STATES CODE)

1. Title of Publication: MISSOURI MEDICINE.
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8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None.
9. For optional completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual) 39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

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11. Extent and nature of circulation. The average number of copies each issue during preceding 12 months are: (A) Total No. copies printed. (Net Press Run), 5,125; (B) Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales, 0; 2. Mail subscriptions, 4,786; (C) Total paid circulation, 4,786; (D) Free distribution by mail, carrier or other means; 1. Samples, complimentary, and other free copies, 256; 2. Copies distributed to news agents, but not sold, 0; (E) Total distribution (Sum of C and D), 5,042; (F) Office use, left-over, unaccounted, spoiled after printing, 83; (G) Total (Sum of E & F—should equal net press run shown in A), 5,125. Actual number of copies of single issue published nearest to filing date: (A) Total No. copies printed (Net Press Run), 5,235; (B Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales, 0; 2. Mail subscriptions, 4,887; (C) Total paid circulation, 4,887; (D) Free distribution by mail, carrier or other means: 1. Samples, complimentary, and free copies. 256; 2. Copies distributed to news agents, but not sold, 0; (E) Total distribution (Sum of C and D), 5,143; (F) Office use, left-over unaccounted, spoiled after printing, 92; (G) Total (Sum of E & F—should equal net press run shown in A), 5,235.

I certify that the statements made by me above are correct and complete.

Jean Duensing, *Managing Editor*

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

Dr. W. McKim Marriott, St. Louis, dean of the Washington University School of Medicine, and Chancellor George R. Throop of Washington University, spent the summer in Germany visiting various German universities.

Upon the invitation of the University of Tennessee in Memphis, Dr. M. Pinson Neal of Columbia served during the summer quarter as a visiting professor of pathology and bacteriology at the University's College of Medicine and as acting pathologist to the Memphis General Hospital. Dr. Neal held these same appointments during the summer quarter of 1932.

The Louise G. Wallace Hospital in Lebanon was dedicated on July 1. The building is a fireproof structure with a capacity of 30 beds. The hospital and equipment cost $50,000. Funds for the erection and maintenance of the hospital were provided for in the will of the late Mrs. Louise G. Wallace.

The Rev. Alphonse M. Schwitalla, S.J., dean of the St. Louis University School of Medicine, has been appointed to a Special Committee on Medical Education and Hospitals of the American Medical Association. The committee will reexamine and reclassify the schools of medicine in the United States in collaboration with the Association of American Medical Colleges and the Federation of State Boards of Medical Examiners. The original classification was made by the Carnegie Foundation for the Advancement of Teaching 24 years ago. There are seven other members of the committee who will undertake the reclassification.

TWENTY-FIVE YEARS AGO

An editorial in the *Journal of the Missouri State Medical Association* stated the following:

"The medical profession is engaged in a crusade against the invasion of its rights to treat the sick in the best possible manner and with the least amount of paternalistic bureaucratic governmental interference. The successful attainment of this ambition will necessitate the intelligent support of every physician and must exceed financial or vocal support. It should not be forgotten that a physician's actions will always speak louder than his words. Every physician is, in a sense, a public relations counselor for himself and his profession. In the final analysis, the relief of the patient, whether suffering pain or foolish fear, is the physician's responsibility. To shirk this responsibility, whether the physician be a specialist, professor or practitioner, is to shame a great profession and bring unnecessary censor to it."

Lloyd Stockwell, M.D., Kansas City, has been appointed as a member of the scientific exhibits committee for the annual meeting of the American Urological Association in Washington, D. C. on May 29-June 1, 1950.

TEN YEARS AGO

The Washington University Medical Alumni Association recently elected Ray D. Williams, M.D. of St. Louis as president-elect. Dr. Heinz Haffner, St. Louis, was installed as president. Dr. H. Rommel Hildreth was elected vice-president and Dr. Richard V. Bradley, Clayton, was elected secretary-treasurer.

Victor B. Buhler, M.D. of Kansas City has been elected president of The College of American Pathologists.—The American College of Chest Physicians elected Alfred Goldman, M.D. of St. Louis as president at the recent meeting in San Francisco.

Dr. Wayne B. Boydston was elected chief-of-staff at the Lexington Memorial Hospital.—The newly-appointed chairman of the board of trustees of Drury College in Springfield is Frank McDowell, M.D. of St. Louis.

Norman A. Welch, M.D., President of the American Medical Association, died on September 3 in St. John's Hospital in Jackson, Wyo. Dr. Welch was at Jackson Park Lodge in Moran, Wyo. to address a dinner meeting of the Wyoming State Medical Society when he was stricken with a massive cerebral hemorrhage.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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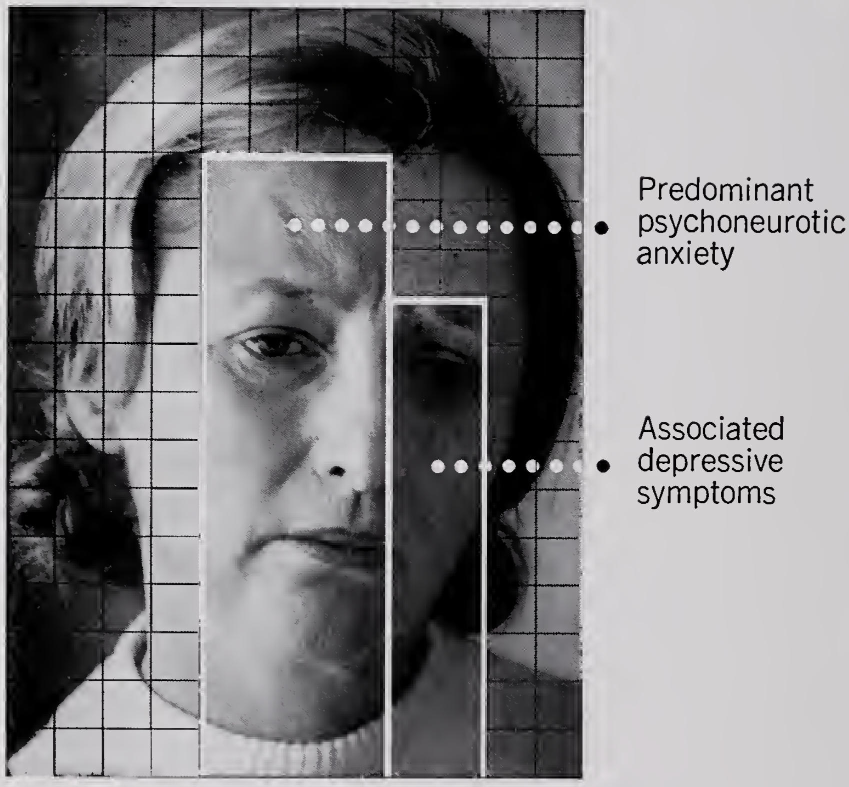
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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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Missouri Medicine

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MSMA

NEWS ROUND - UP

December, 1974

Fraudulent 'invoice' mailed to physicians

Several MSMA members have indicated they received a fraudulent "invoice" for $185 for purchase of "The International Medical Directory of Physicians."

An international swindle aimed at defrauding more than 300,000 American physicians of $185 each has been nipped by a fraud order issued by the U.S. Post Office with the cooperation of the AMA.

Physicians throughout the U.S. recently received in the mails what appears to be an invoice for $185 for the purchase of "The International Medical Directory of Physicians" by "Mayo Research and Publishing Co." The statements were mailed from California, but the return address of the so-called publishing company is Hong Kong.

Issuance of the postal fraud order Nov. 1 means that all mail addressed to the Hong Kong address will be stopped and returned to the sender. It was feared that in some offices the doctors' assistants would routinely forward checks in response to the "invoice."

Solicitations not approved

Physicians are reminded that solicitations for listing in the "U.S. Medical Directory" are not sponsored or approved by the AMA or MSMA.

The solicitation for the directory has a return address in Miami, Florida, and includes a $10 charge for listing the physician's name.

The only AMA-sponsored directory is the **American Medical Directory**. *There is no charge for listing in the AMA publication.*

The high cost of coverage

About $1.58 of every $10 patients pay physicians goes to cover his malpractice insurance, Dr. Malcolm C. Todd, president of the AMA recently told the national press.

Dr. Todd, a California surgeon, said some specialists pay as much as $12,000 a year for malpractice insurance. He added that the reasons for the high premiums are the increased number of claims and the higher awards.

Area PSRO offices set up in Missouri

In compliance with Public Law 92-603, the Professional Standards Review Organizations law, a statewide support center and area PSRO offices have been established in Missouri.

For information concerning PSRO, physicians should contact the office in their area.

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Kansas City, Missouri 64108

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Mid-Missouri PSRO Foundation Area II
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Jefferson City, Missouri 65101

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Mr. William C. Lindsley, Jr., Executive Director
CEMPROC Area III
Suite 212
4625 Lindell Boulevard
St. Louis, Missouri 63108

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Mr. E. Mark Halvorson, Executive Vice-President
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P. O. Box 862
Jefferson City, Missouri 65101

Court voids vote on amalgamation

The vote for the proposed amalgamation of the St. Louis Medical Society and the St. Louis County Medical Society was disallowed before the ballots could be tallied.

St. Louis Circuit Judge Michael Godfrey, acting on a suit brought by a St. Louis physician, ruled that the procedure followed by the city society to approve the merger was inconsistant with the society's bylaws. He said that the balloting, which was conducted during a four-hour period at the society Headquarters, was invalid and ordered the ballots destroyed.

A total of 237 ballots were cast by city society members. There are approximately 1,600 members in the society.

Members of the St. Louis County Medical Society had overwhelmingly favored the amalgamation in a mail ballot by a margin of 303 to 134. More than 80 per cent of the county's 527 eligible voters cast ballots.

The action does not prevent the two societies from proceeding with new plans to merge.

Council to meet

An interim report of the MSMA Ad Hoc Committee on Professional Liability Insurance will be presented at the December meeting of the MSMA Council.

The Committee is working in conjunction with the Rollins Burdick Hunter Company in studying the professional liability situation in Missouri.

The Council, which will meet at the Downtown Holiday Inn in Jefferson City on December 15, will consider the MSMA budget for 1975 and receive reports from several committees.

PSRO pamphlet available

The AMA has prepared a new pamphlet entitled "PSRO — Some Questions and Answers" which is now available.

Physicians desiring a copy of the pamphlet should write either the AMA or the Missouri State Medical Association.

What should you tell the press about a patient?

Many MSMA members are often faced with the situation of releasing information about patients to the news media.

Although individual cases may differ, the Judicial Council of the American Medical Association has approved guidelines which aid in the smoother flow of accurate medical news from the medical profession to the media.

The following is quoted from the pamphlet, "Guidelines for Physicians in their Relations with the Media," and can be divided into two parts — Patient Consent Not Needed and Patient Consent Needed.

Patient Consent *Not* Needed

Because certain news (1) is a part of the public record, or (2) is a matter of concern to civil authorities, it is readily available for publication. Physicians should cooperate with the press to insure that medical news of this sort is available more promptly and more accurately than would be possible without their assistance.

News in this category, known as news in the public domain, includes: births, deaths, accidents, and police cases.

The following information in the public domain can be made available without the patient's consent:

(a) Personal information: patient's name, address, age, sex, race, marital status, employer, occupation, name of parents in case of births, name of next-of-kin in case of deaths.

(b) Nature of accident:

Only general information regarding injuries will be released. This consists of the name of the injured portion of the body such as back injury, etc.

It may be stated that there are internal injuries.

If the patient is unconscious when brought to the hospital, a statement to that effect may be made.

Statements regarding the circumstances surrounding shootings, knifings, and poisonings are properly police matters and questions whether they were accident or otherwise should be referred to the appropriate authorities.

A statement may be made to the effect that the patient was injured by a knife or other sharp instrument, but no statement may be made as to whether or not it was assault, accident, or self-inflicted.

A statement may be made that the patient received burns and the member of the body affected may be indicated.

No statement may be made that there was a suicide or attempted suicide.

No statement may be made to the effect that intoxication or drug addiction was involved.

No statement may be made that moral turpitude was involved.

(c) Diagnosis and prognosis:

Inasmuch as a diagnosis may be made only by a physician and may depend upon X-ray and laboratory studies, no statement regarding diagnosis should be made except by or on behalf of the attending physician. For the same reason prognosis will be given only by the attending physician or at his direction.

(d) Patient's condition:

A statement may be made as to the general condition of the patient using the following classifications: minor injuries or similar general diagnosis, good, fair, serious, critical.

Patient Consent Needed

When information concerning a specific patient is requested, the physician must obtain the consent of the patient or his authorized representative before releasing such knowledge. The patient's decision is final under the law.

A physician may, within the limits of good taste, encourage the patient or his family to state the cause of illness, or the cause of death, when this information is requested by a bonafide representative of the press. Where a person of public interest is involved, and the release of information has been authorized, the physician may arrange for regular bulletins concerning the person.

The ethical physician will use restraint and good judgment regarding the use of his name in connection with such published reports.

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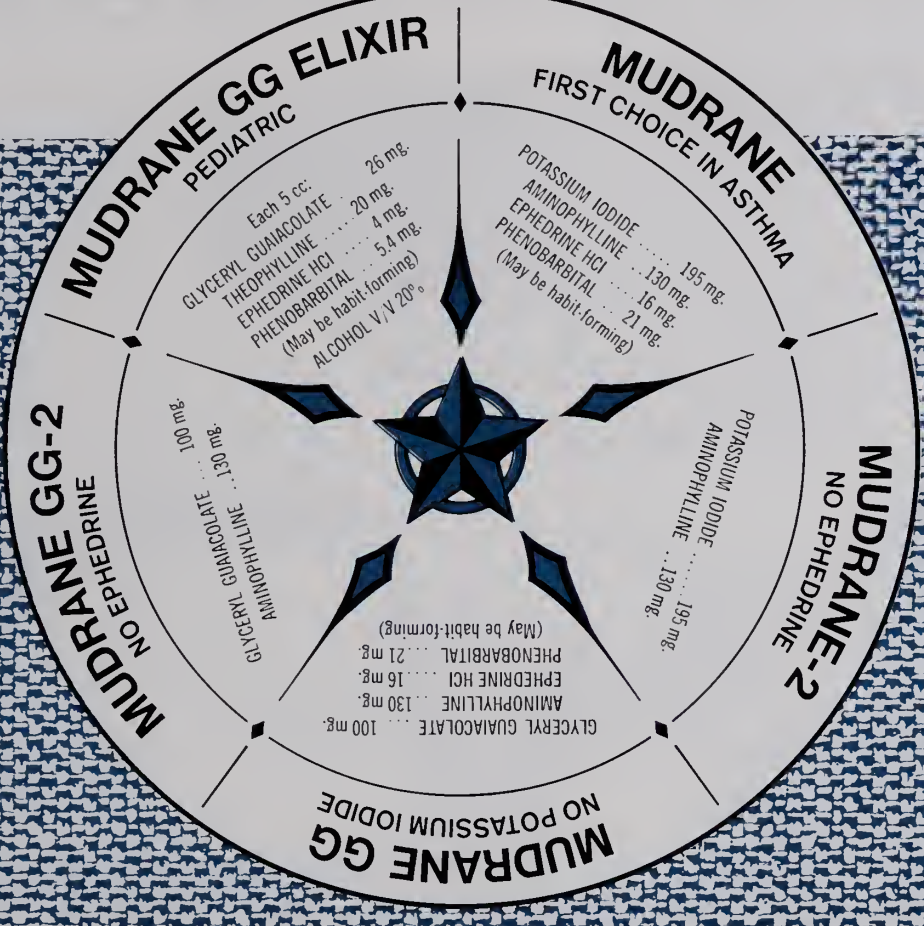

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Where Do We Stand With the Primary Treatment of Breast Cancer?

Special Article

On Sept. 30, 1974 at the National Institutes of Health (NIH) in Bethesda, Md., a meeting was held entitled "A Report to the Profession from the Breast Cancer Task Force of the National Cancer Institute."

The meeting was chaired by Dr. Nathaniel Berlin, Director of the Division of Cancer Biology and Diagnosis and Chairman of the Breast Cancer Task Force at the NCI. As Dr. Berlin stated in his introductory remarks, the Breast Cancer Task Force was first authorized by Congress in 1966 but really began its present thrust in 1970, at which time a major redirection of the program was initiated.

TABLE 1

Breast Cancer Risk Factors Identified by Dr. Leis

	Incidence vs. General Population
MAJOR FACTORS	
Sex 99% female - 1% male	
Age 75% of breast cancers over the age of 40	
Previous cancer in one breast	5 - 1
Precancerous mastopathy	5 - 1
Family history of breast cancer	
Daughter of mother with breast cancer	2 - 1
Sister of patient with breast cancer	2.5 - 1
Fertility	
Infertile vs. fertile	1.5 - 1
Less than 3 children vs. more than 3	2 - 1
Age of first pregnancy	
Over 25 years vs. less than 25	2 - 1
Over 31 years vs. less than 21	3 - 1
OTHER FACTORS	
Fibrocystic breasts vs. normal breasts	2 - 1
Early menarche and prolonged menstrual history vs. normal	2 - 1
Left side vs. right side	11 - 10
High dietary fat intake vs. low	Increased
Wet cerumen (earwax) vs. dry	Increased
Normal menopause vs. oophorectomy before age 37	Increased
Hypothyroid vs. euthyroid	Increased
Other organ cancers (endometrial, salivary, ovary, colon) vs. none	Increased
Western Hemisphere women vs. Eastern (United States vs. Japan)	Increased
Cold climate vs. warm	Increased
High socio-economic women vs. low (U.S. whites vs. Puerto Rican)	Increased
Estrogen administration to nulliparous or late parous vs. none	Possible increase
No nursing vs. prolonged nursing	Questionable increase
Women with viral particles in milk vs. those without	Questionable increase
Breast trauma vs. none	Questionable increase

Reprinted with permission from Breast Cancer Risk Profile Used in Detecting Preclinical Disease. JAMA 222: 1484-1485, Dec. 18, 1972.

Under this redirection, a steering committee was set up by the task force and the decision was made to look at the totality of the breast cancer problem. The success of the work today is attributable to the quality of the original planning. The planning was carried out under a system-planning approach referred to as convergence technique and with Mr. Louis Caresse as head of the planning section. The final draft of the plan was completed in 1971. The Bethesda meeting provided formal presentations on the epidemiology, virology, experimental biology, diagnosis and treatment of breast cancer. The significant progress made in every area will be reported in greater detail in scientific papers that will be subjected to peer scrutiny and verification. All that can be accomplished in this review is to highlight a few of the more significant observations and to acquaint you with the role that the Cancer Research Center-Ellis Fischel State Cancer Hospital (CRC-EFSCH) staff has played in facets of the program.

The epidemiologists now associate the disease with obesity. Though familial tendencies exist, these may be environmental as much as hereditary. At least, no specific gene has yet been implicated. They have identified a host of factors associated with increased and decreased risk, none of which is significant enough to be of much use clinically. The data presented were not much different from those previously reported by Leis (Table 1).

The virologists have known for years that mouse cancer can be transferred by viruses in the maternal milk. However, evidence for a viral causation of human breast cancer has eluded investigators until recently. Biochemical and biological evidence given at the meeting was to the effect that viruses may have a role in the causation of some human breast cancers. However, this observation has not been reduced to technology applicable to the prevention or treatment of the cancers.

The experimental biologists provided some very useful observations to better explain the clinical and epidemiologic observations regarding the interrelations between nutrition, growth and sex hormones and the induction and regression of breast cancer.

In the area of diagnosis, presentations were made on the progress in the 27 breast cancer detection centers being operated throughout the country under contract from the National Cancer Institute (NCI) and the American Cancer Society (ACS). Data were presented on the potential future utility of ultrasound mammography and breast fluid analysis as diagnostic tools. One of these 27 centers was made operational at the CRC on July 1, 1974 under the direction of Dr. Ned Rodes. A review of this Missouri demonstration project is in a companion paper in this issue (page 685). Data from these centers will be used to evaluate the feasibility and value of early diagnosis of breast cancer through analysis of the nationally compiled and analyzed statistics.

In the treatment area, presentations were made by Drs. Edwin and Bernard Fisher from the University of Pittsburgh. The work in this area is being largely carried out through the National Surgical Adjuvant Breast Project (NSABP) with Dr. Bernard Fisher as project director. Several staff members at CRC-EFSCH have been active participants in this phase of the program since its initiation.

A meeting entitled "A Report to the Profession from the Breast Cancer Task Force of the National Cancer Institute" was held at the National Institutes of Health in September. This timely report includes significant observations of highlights of the meeting by the author and a description of the role that the staff at the Cancer Research Center-Ellis Fischel State Cancer Hospital has played in facets of the Task Force's program.

Dr. Spratt is Director of the Cancer Research Center and Chief Surgeon at Ellis Fischel State Cancer Hospital.

This investigation was supported in part by Public Health Service Research Grant CA-08023 from the National Cancer Institute.

Statistical studies done at the CRC-EFSCH by Drs. Donegan, Spratt and Francis Watson provided identification of variables associated with the success and nonsuccess of primary treatment. This background work has enhanced the value of the initial research planning. Also, the statistical approach of univariate and multivariate analyses developed by Dr. Watson, head of the Biomathematics Section of the CRC, was adopted by the statistical center at Pittsburgh. Currently, Dr. Spratt is the NSABP project director at CRC-EFSCH and is assisted by Dr. Camilo Paig as project radiothera-

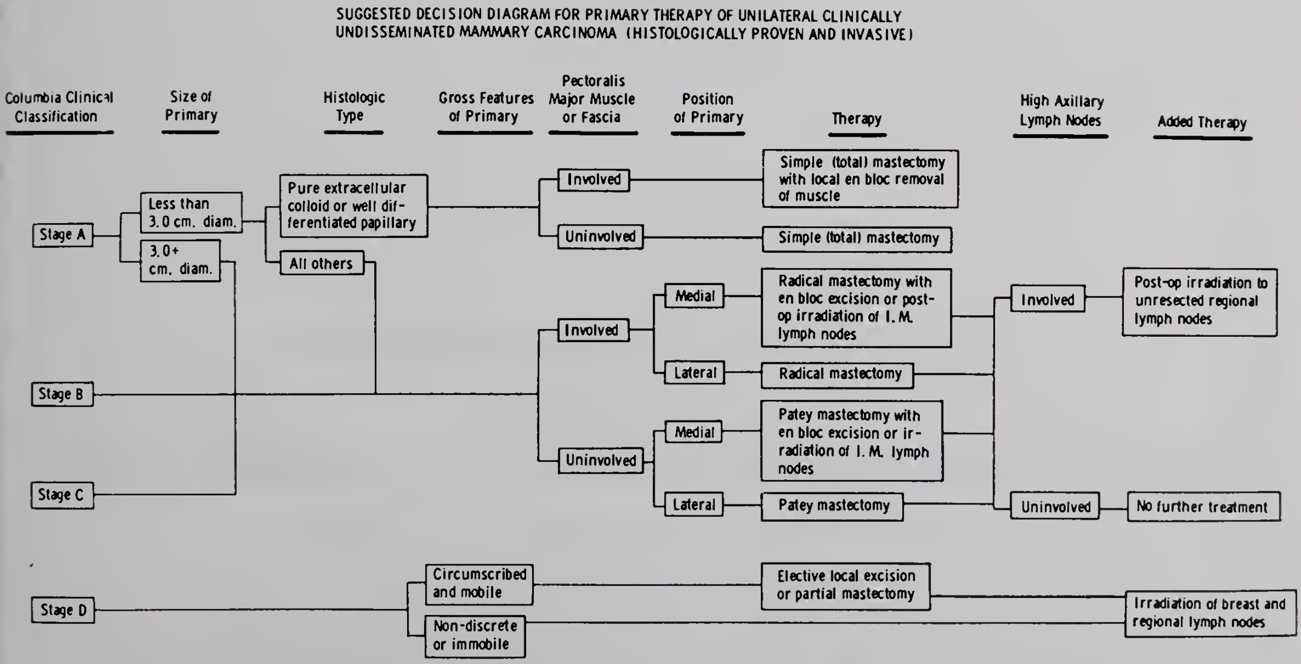
SUGGESTED DECISION DIAGRAM FOR PRIMARY THERAPY OF UNILATERAL CLINICALLY UNDISSEMINATED MAMMARY CARCINOMA (HISTOLOGICALLY PROVEN AND INVASIVE)
Columbia Clinical Classification
Size of Primary
Histologic Type
Gross Features of Primary
Pectoralis Major Muscle or Fascia
Position of Primary
Therapy
High Axillary Lymph Nodes
Added Therapy
Stage A
Less than 3.0 cm. diam.
3.0+ cm. diam.
Pure extracellular colloid or well differentiated papillary
All others
Involved
Uninvolved
Simple (total) mastectomy with local en bloc removal of muscle
Simple (total) mastectomy
Stage B
Stage C
Involved
Uninvolved
Medial
Lateral
Medial
Lateral
Radical mastectomy with en bloc excision or post-op irradiation of I. M. lymph nodes
Radical mastectomy
Patey mastectomy with en bloc excision or irradiation of I. M. lymph nodes
Patey mastectomy
Involved
Uninvolved
Post-op irradiation to unresected regional lymph nodes
No further treatment
Stage D
Circumscribed and mobile
Non-discrete or immobile
Elective local excision or partial mastectomy
Irradiation of breast and regional lymph nodes

Fig. 1 Reprinted with permission from Donegan, W. L.: Mastectomy in the Primary Management of Invasive Mammary Carcinoma. Adv. Surg. 6:1-101, 1972, p. 92.

pist, Dr. Carl Kardinal as chemotherapist and Dr. Carlos Perez-Mesa as project pathologist. Ms. Phyllis Harris, director of nursing on the Clinical Research Unit, and Ms. Claudette Thomure, secretary for the project, provide experienced support staff.

The project involves some 51 institutions in the United States. The protocols involve a clinical evaluation of many alternate approaches to treatment, all of which hold promise for controlling the disease. All patients are fully informed of the study and are entered into it only if they volunteer as participants. The protection of the rights of human participants is rigidly monitored according to federal regulations.[1]

Complete follow-up is carried out to evaluate treatment. Several facets of the study have already given significant observations. First, it is now evident that many breast cancers arise from multiple points in the breast. Thus, though a "lumpectomy" may remove grossly palpable cancer, it may leave other undetected cancers in the breast. Many patients who had a total mastectomy have required a second major operation to remove enlarging axillary nodes that contained cancer.

As the program presentations stressed, all results have to be reported as "trends." Final conclusions must await the completion of the study. The trends do permit predictions for the future. These predictions are that a mastectomy, that will be radical for some cases, will leave the patient with a "minimum tumor load" after surgery. Beginning in the early postoperative period, chemotherapeutic drugs, singly or in combination, will be used to suppress or eradicate residual microscopic foci of systemic cancer. Immunotherapy still must be evaluated by protocols not yet implemented. For cancers with axillary lymph node metastases, the short term trends were equivalent for radical mastectomy alone and total mastectomy followed by radiotherapy. Frequency of subsequent axillary dissection and long-term results are still to be evaluated.

Pending the completion of this NSABP work, the approach to the primary management of breast cancer which the results presently in the literature support are given in Fig. 1. References on other recent work on breast cancer incorporating data from the EFSCH may be obtained by writing to the author.

Reference

1. Protection of Human Subjects. Federal Register 39 (Part II). Washington, D. C., Department of Health, Education, and Welfare, May 30, 1974.

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WASHINGTON

The American Medical Association is now in the process of reviewing and updating its position on national health insurance, Malcolm C. Todd, M.D., has told Washington groups.

"Our objective is to make the AMA's national health insurance proposal more flexible, while at the same time maintaining certain basic precepts," Dr. Todd said.

"If necessary, we may compromise on the method of financing we adopt. But, we are not willing to fund national health insurance through an increase in Social Security taxes nor are we willing to see the program administered by the Social Security Administration.

"We want a financing mechanism for comprehensive health insurance that will do the most at the least cost. This could involve:

*Increase employer-employee contributions for private health insurance;

*The use of general tax revenues;

*Or, an individual tax credit to be applied toward full health care protection. This latter method was, of course, the method employed in Medicredit.

"The important point is that we cannot countenance greater fiscal and bureaucratic authority for the Social Security Administration or an increase in the Social Security tax.

"Any payroll tax, whether collected under Social Security or not, constitutes the most insidious form of taxation that can be invoked by government. It is a totally regressive tax that weighs heavily on low and middle income workers and lightly on the affluent.

"Finally, the measure that emerges will provide comprehensive health care benefits as well as protection against the catastrophic costs of prolonged illness for every American," Dr. Todd said.

* * *

The Department of Health, Education and Welfare has announced that commencing with the first of the new year, the Medicare hospital deductible will jump to $92. The present deductible is $84.

HEW said that the $92 deductible is equivalent to the average cost of one day of hospitalization. The increased payment was brought about by rising hospital costs, HEW said.

The Medicare law requires an annual review of hospital costs under Medicare and an adjustment of the portion of the bill for which a Medicare beneficiary is responsible, if the costs have risen substantially.

When the hospital deductible amount changes, the law requires comparable changes in the dollar amounts that a Medicare beneficiary pays toward a hospital stay of more than 60 days or an Extended Care Facility (ECF) stay of more than 20 days.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay $23 a day for the 61st through the 90th day, up from the present $21 per day. If he has a posthospital stay of over 20 days in an ECF, he will pay $11.50 per day toward the cost of the 21st day through the 100th day, up from the present $10.50 per day.

If a beneficiary uses his "lifetime reserve" days, the extra 60 hospital days a beneficiary can use when he needs more than 90 days of hospital care in the same benefit period, will cost him $46 for each reserve day used, instead of the present $42 per day.

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Notes of interest from Here .... and There

Dr. James A. Felts, St. Louis, has been elected speaker of the House of Delegates of the American Society of Anesthesiologists. He also has served the ASA as vice-speaker of the House of Delegates, a member of the Board of Governors of the American College of Anesthesiologists and as a member of various ASA committees. Dr. Felts is assistant professor of anesthesiology at the Washington University School of Medicine.

Dr. Frederick J. McCoy of Kansas City has been named president-elect of the American Society of Plastic and Reconstructive Surgeons.

Dr. Marion S. DeWeese, Columbia, presented a film on operating procedures during the 25th Cine Clinic at the Clinical Congress of the American College of Surgeons in Miami Beach, Fla. recently. The film is entitled "Anatomical Considerations of Thyroidectomy." Dr. DeWeese is the A. Alton Jones professor and chairman of the Department of Surgery at the University of Missouri-Columbia Medical Center.

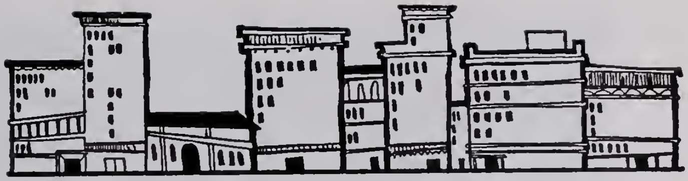
Dr. Harold D. Lankford, Mexico, has been elected to the Board of Trustees of the Audrain County Hospital.—**Dr. Leland Pfefer**, Columbia, has been elected chief of the medical staff of Boone County Hospital. **Dr. Trevor Watson** was elected vice-chief of staff and **Dr. Ken Kays** was reelected secretary-treasurer.

Dr. Henry E. Oppenheimer, Kansas City, was the moderator of a breakfast session on "Youth and Diabetes" at the Regional Meeting of the American Diabetes Association in Minneapolis, Minn. in September. In October, Dr. Oppenheimer was the principal speaker at the organizational meeting of the Washington (Mo.) branch of the St. Louis Diabetes Association.

Dr. C. W. Chastain, Farmington, has been asked to become a consultant for family practice for *Medical Times*, a nationwide medical magazine. He will serve as editor for family practice matters for the journal.

Dr. Richard A. Osbourn, M.D., Fulton, has been elected chief of staff at Callaway Memorial Hospital. Other newly elected officers are **George Groce**, M.D., vice-chief of staff, and **E. Dale Brandt**, D.O., secretary.

From the Medical Schools



ST. LOUIS UNIVERSITY

Two distinguished graduates of the St. Louis University School of Medicine were honored with alumni merit awards, one of which was awarded posthumously, at the Civic Dinner at the Chase-Park Plaza Hotel which concluded Founders Week activities held October 18-27.

Dr. Raymond O. Muether, a distinguished physician and researcher, knew that he had been chosen for the award before his death in July. His son, John, accepted it from *Rev. Daniel C. O'Connell,* S.J., president of St. Louis University. Dr. Muether, a member of the medical faculty since 1932, held the dual rank of clinical professor of internal medicine and clinical professor of pathology. He received the M.D. degree in 1929 and the Master's degree in internal medicine in 1933. He also took his premedical studies at St. Louis University and his postgraduate training in internal medicine at the St. Louis University Hospitals.

Dr. Muether was active through the years of his practice in numerous medical organizations and served as president of the Missouri State Medical Association in 1954. He was director of laboratories, director of medical education and medical director of the St. Louis County Hospital. With reorganization of the St. Louis County health related services into the new Department of Community Health and Medical Care in 1973, he became associate director of the combined departments.

Dr. James H. Sammons, new Executive Vice-President of the American Medical Association, earned the M.D. degree from the School of Medicine in 1951. Before taking his appointment as top administrative officer of the AMA, he was chairman, and youngest member, of the AMA Board of Trustees. Dr. Sammons was born in Montgomery, Ala. in 1927.

Dr. Sammons has been active in professional associations on the local, state, regional and national level. He is a 15-year board member and former president of the Texas Medical Association and a founder of the Texas Political Action Committee. Until his recent AMA appointment, he was managing partner of a ten-member family group practice in Baytown, Tex. and a member of the clinical faculty at Baylor College of Medicine.

Dr. James H. Sammons, Executive Vice-President of the American Medical Association (center), receives alumni merit award in medicine from Rev. Daniel C. O'Connell, S.J., president of St. Louis University. Dr. Edwin G. Eigel, vice-president for academic administration (far left), participated in the presentation.

UNIVERSITY OF MISSOURI-KANSAS CITY

Ned W. Smull, M.D. has been appointed Vice-Provost for Health Sciences at UMKC. Dr. Smull will continue as Director and Chairman of Pediatrics at Children's Mercy Hospital. *Robert S. Mosser,* M.D. has been appointed Associate Provost for Health Sciences. *Andrew McCanse,* M,D. has been appointed Associate Dean for Selection and Student Affairs in the School of Medicine. *Walter J. Stelmach,* M.D. has been appointed Assistant Dean and Chairman of the Council on Evaluation.

A three-year contract in the amount of $746,000 has been signed between the Department of Health, Education and Welfare and the UMKC Office of the Provost for Health Sciences for Project PEPE (Profile Examination for Physician Extenders). The goal of the project is to develop a profile examination for nonphysician primary care practitioners and to help develop a curriculum for individuals entering this field. The Quarterly Profile Examination developed by the Council on Evaluation in the School of Medicine and taken by medical students, residents and faculty will provide a pattern for the new project. Dr. Smull is Project Director and Dr. Mosser is Codirector.

The new UMKC Medical School building was dedicated on Oct. 27, 1974. Among the speakers

(Continued on page 702)

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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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CARL G. KARDINAL, M.D., ASA BARNES, M.D.
and REGINALD P. PUGH, M.D., *Columbia*

Acute Leukemia: A Disease of Medical Progress?

Case Reports

It is generally accepted that acute nonlymphoblastic leukemia may occur in the terminal phase of several of the more chronic myeloproliferative disorders such as polycythemia vera, myelofibrosis and paroxysmal nocturnal hemoglobinuria.[1, 2] Chronic myelogenous leukemia also may be considered a preleukemic state with a terminal acute leukemia as part of its natural history.[3] Lymphocytic leukemias are also well known complications of the non-Hodgkin's lymphomas,[4] but acute leukemia is not a recognized complication of the other hematologic malignancies, i.e., Hodgkin's disease and multiple myeloma.[5, 6]

During the last ten years, the association of acute leukemia as a complication of Hodgkin's disease and other malignancies has been reported with increasing frequency.[7-10] We would like to report two cases of acute nonlymphoblastic leukemia. The first case is that of a 27-year-old woman who had previously been treated for Hodgkin's disease, and the second is that of a 73-year-old woman with well-documented multiple myeloma.

Case Reports

Case #1. A 27-year-old white woman presented to Ellis Fischel State Cancer Hospital (EFSCH) in December 1969 for evaluation of bilateral cervical and axillary adenopathy, low grade fever and night sweats. Lymph node biopsy revealed Hodgkin's disease of nodular-sclerosing type. A staging laparotomy was performed and Hodgkin's disease involving her spleen and para-aortic nodes was found. She was believed to be Stage IIIB and was treated with MOPP (nitrogen mustard, vincristine, prednisone and procarbazine).

She did well until September, 1970 when she developed recurrent adenopathy. This was treated with 4,000 rads to the left axilla and left supraclavicular area. She was continued on a modified chemotherapy program consisting of cyclophosphamide, procarbazine and prednisone until February, 1974 when she developed refractory anemia. A bone marrow examination in March, 1974 was nondiagnostic.

In August, 1974, she returned and was profoundly anemic (hemoglobin level, 7.0 gm/100 ml) with petechiae on her face and extremities (platelet count, 10,000/cu mm). A bone marrow examination revealed 50% myeloblasts and promyelocytes. No Auer rods were noted. Treatment for acute leukemia with cytosine arabinoside and thioguanine was initiated. Her Hodgkin's disease has remained in remission (Fig. 1).

Although acute leukemia is not a recognized complication of Hodgkin's disease and multiple myeloma, its association with these malignancies has been reported with increasing frequency in recent years. The authors present two such case reports. Dr. Kardinal is Director of Internal Medicine and Dr. Barnes is Associate Pathologist at Ellis Fischel State Cancer Hospital. Formerly Chief of Internal Medicine at EFSCH, Dr. Pugh is now Director, Division of Medical Oncology, Allegheny General Hospital in Pittsburgh, Pa. This investigation was supported in part by Public Health Service Research Grant #CA-06800 from the National Cancer Institute.

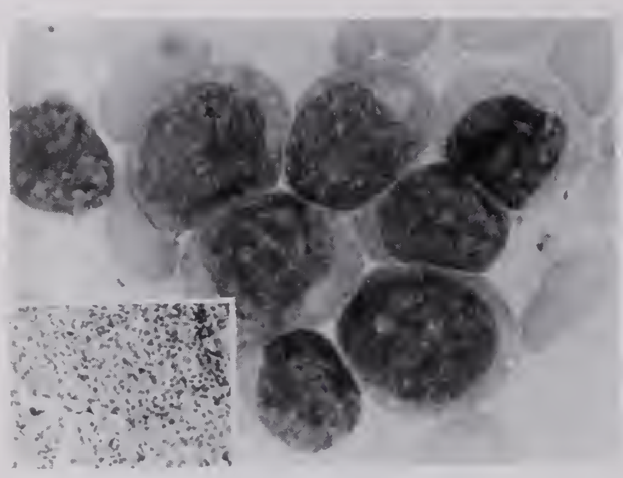

Fig. 1 Myeloblasts in the bone marrow (Case #1). *(Inset)* Hodgkin's disease in a cervical lymph node from this patient. The *arrow* points to a Reed Sternberg cell.

Case #2. A 73-year-old white woman had a diagnosis of multiple myeloma made at EFSCH in April, 1968. Because of multiple osteolytic lesions, she was treated initially with local radiation therapy (2,500 rads) to the left shoulder and, then, with intermittent high doses of melphalan (12 mg/day for four days repeated at six-week intervals). After several months, severe anemia developed. This responded to testosterone enanthate sufficiently to permit reinstitution of melphalan treatment.

Gradually, the patient became pancytopenic. In March, 1974, investigation of this problem led to bone marrow examination which revealed extreme hypocellularity with marked myeloid dysplasia and a high percentage of myeloblasts. No Auer rods were observed.

A diagnosis of acute myelogenous leukemia was made. Because of bone marrow hypocellularity, the patient was treated with transfusions only. She died at home in June, 1974, and no autopsy was done (Fig. 2).

COMMENT

Since acute leukemia is probably not part of the natural history of Hodgkin's disease or multiple myeloma, most of the speculation regarding etiology of the association has related to role of therapy. All of the reported cases of acute leukemia complicating Hodgkin's disease or myeloma have occurred in patients who have been treated with radiation therapy or chemotherapy or both. For the last 50 years, a clear association between radiation and leukemogenesis has been recognized. Studies of the Atomic Bomb Casualty Commission have demonstrated conclusively an increased incidence of not only acute leukemia but, also, chronic myelogenous leukemia and myelofibrosis in the survivors of the Hiroshima and Nagasaki explosions.[11, 12]

There is strong presumptive evidence that chemotherapeutic drugs and, especially, the radiomimetic alkylating agents may be leukemogenic. It also seems that patients treated with both radiation and chemotherapy are at greater risk of developing acute leukemia than patients treated with either radiation therapy or chemotherapy alone.[13, 14]

The mechanism or mechanisms by which chemotherapeutic agents may induce acute leukemia have remained speculative. However, attention has been focused on suppression of the patient's immune surveillance system. Most anticancer drugs in use today are immunosuppressive. Transplantable mouse leukemia may be enhanced by methotrexate. Methylcholanthrene-induced sarcomas in mice take with a higher frequency in animals treated with cyclophosphamide.[15] There is an increased incidence of neoplasms, especially malignant lymphomas, in transplant patients treated with immunosuppressive drugs.[16] Perhaps the anticancer drugs induce increased immunologic tolerance to malignant cells or produce defects in immunologic surveillance.

The data confirming a cause-effect relationship between cytotoxic therapy and the induction of

(Continued on page 689)

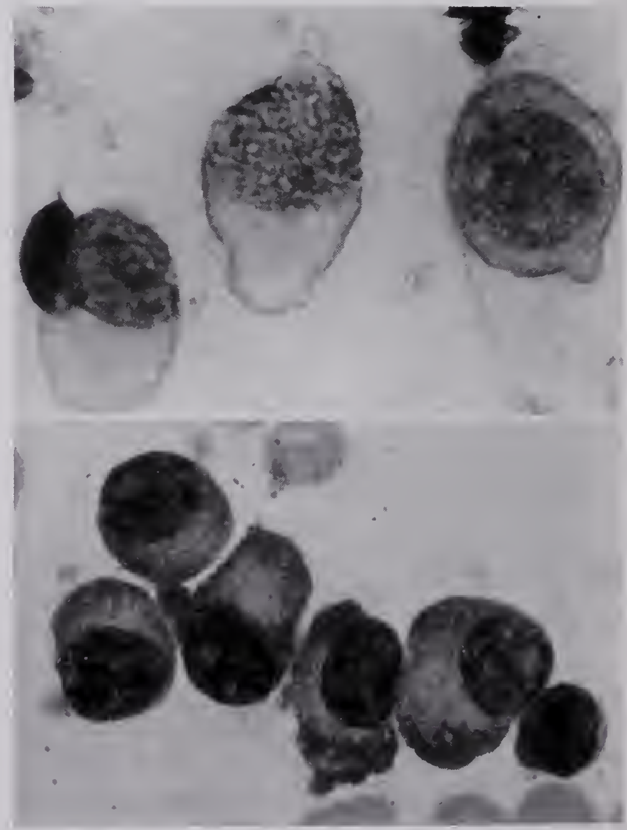

Fig. 2 *(Top)* Three myeloblasts in the bone marrow (Case #2). *(Bottom)* Plasma cells present in this patient's bone marrow when the initial diagnosis of multiple myeloma was made.

NED D. RODES, M.D., CHARLES W. BLACKWELL, M.D.
and **CORINNE FARRELL, M.D.,** ***Columbia***

Missouri Breast Cancer Demonstration Project

CANCER OF THE BREAST is a disease which was the primary cause of death for an estimated 800 people in Missouri in 1974. More than 99% of these 800 people were women. There were approximately 2,200 new cases of breast cancer in Missouri in 1974. In the United States there are about 90,000 new cases annually and about 33,000 deaths.[1] Cancer of the breast is the most common major cancer of women and the leading cause of death from causes in the fourth and fifth decades of life. The same generally holds true for other countries of the Western World.[2]

In 1891 Sir William Halstead described the operation now known as the radical mastectomy. With various modifications, it remains the point of reference in the treatment of breast cancer. In addition to surgical treatment, both radiotherapy and chemotherapy have been employed as therapeutic efforts. Most recently, research is being done in the field of immunotherapy.

In spite of space age technology and an improved survival in other cancers, however, the cure rate of breast cancer remains at about 50% for all cases at five years with a continuing loss of consequence in the second five years.

Faced with these facts, the National Cancer Institute and the American Cancer Society jointly have established 27 Breast Cancer Detection Demonstration Projects in an effort to detect the unsuspected, occult, nonpalpable breast carcinoma so that an early diagnosis and treatment regimen might be started. The Centers were selected for geographic distribution and potentiality of services. Such a project was established at the Cancer Research Center in Columbia, Mo. on June 1, 1974. Of the 27 projects, Missouri's is the only one located in a rural area. The major objective of all projects is the earlier diagnosis of this disease which has remained fairly static in its frequency and curability. This emphasis on early detection has a proven precedent in cancers of the cervix, for which the Pap smear has indicated its importance.

The value of earlier diagnosis and earlier treatment also has been established in mammary cancer.[3, 4] As a consequence, mass screening for the earlier detection of breast cancer is in progress. The main priority group is women who are 35 through 74 years of age, who are asymptomatic and who are willing to participate in the full five years of annual examinations.

These examinations consist of (1) a medical history utilizing American Cancer Society volunteers who are trained as interviewers; (2) a physical examination of the breast by a nurse-clinician under the supervision of a physician; (3) a thermal image of the skin temperature by an instrument known as a thermograph; (4) an x-ray of the breasts by the method of xeroradiography.

Thermography is a technique that provides a hard copy, permanent record of the thermal image of the screenee. It is a pictorial presentation of the temperature variations of a surface[5, 6] infrared emission of the skin. Its end product is an image or picture of the temperature variations of the surface of the breasts. The screenee undresses to the waist and "cools" in a room kept at 68F to 70F for 12 minutes so as to produce a stable temperature background prior to the examination.[7] Warm areas of "heat trapping" by clothing are eliminated, but abnormally warm areas of the patient are not affected by this cooling procedure.[8] Basically, three projections are obtained: an anterior view and two oblique views (right and left). The examined area included is from the shoulders to the upper abdomen, while the screenee stands with her hands placed behind her head. Presently we are using polaroid film as our permanent thermograph image method for interpreting and storing for comparison of future examinations. We are working with 70 mm film as a possibly less expensive presentation of the image. Thermography is an innocuous, noninvasive technique and takes about 18 minutes of the total patient examination time.

The breast thermogram interpretation is based upon a comparison of the surface temperatures of the two breasts.[5] Thermography does not distinguish between active benign and malignant breast disease. Many authors believe that heat produced by cancer or by some other biologically active process is the result of its accelerated metabolic rate compared to the surrounding tissue.[5] However, not all tumors or abscesses generate enough heat to produce a variation unless they are invading the

The Missouri Breast Cancer Demonstration Project in Columbia is the only rurally located project of 27 established by the National Cancer Institute and the American Cancer Society. The major objective of the projects is the earlier diagnosis of cancer of the breast. The authors report on research techniques being utilized in the mass screening now in progress. Dr. Rodes is Project Director and Dr. Blackwell and Dr. Farrell are Consultants in Radiology at the Project. This investigation was supported in part by General Research Support Grant #FR-05608 from the National Institutes of Health.

skin or are very superficially located. There may be no direct relationship between the "hot spot" or increased temperature emission and the heat source.[5]

The normal thermogram has a variety of thermal patterns: (1) avascular or lack of vessel pattern, (2) minimally vascular, (3) moderately vascular and (4) highly vascular. These patterns may change with alcoholism,[5] before and after smoking,[7] hormonal intake[5] and ovulatory cycle.[8, 9]

The abnormal thermograms can demonstrate a unilateral exaggeration of the superficial venous pattern[5] and an increase in relative or absolute temperature difference (machine dependent) in the temperature of the veins as compared with the contralateral side or area. Also, a localized area of increased temperature can signify skin invasion. Other abnormal findings can include increased unilateral heat emission about the areola, diffuse increase of temperature of the entire breast surface with an engorged venous pattern and the "edge sign" thermographic representation of skin retraction with the loss of the usual symmetrical smooth contour to a flattening of a localized area of the breast.[10]

The published results of screening by thermography alone or in tandem with the modalities of physical examination and mammography vary greatly from Isard and associates' 72% suspicious thermograms[11, 12] and Furnival and coworkers' report of 50% of 74 reported cancer patients.[13] Dodd and colleagues reported that of 4,726 patients with 195 cancers, there was a true positive rate of 85% to 87%. Not all large tumors show enough heat to produce a positive thermogram.[5]

Other breast diseases can yield a positive thermogram. For example, 50% of fibroadenomas will give a positive thermogram.[5] Therefore, a false positive of 15% is not unusual.

Thermography's role in the screening project is one that works best in tandem, is a complementary technique to both physical examination and mammography and is for the asymptomatic patient as well as the patient with previous mastectomy.

The fourth modality, mammography, has proven to be an effective method of detecting some preclinical breast cancers. It also is helpful in the differential diagnosis of palpable breast masses because it is fairly reliable in distinguishing benign from suspiciously malignant lesions. It is not an examination that is intended to replace physical examination nor should it be used in lieu of an indicated surgical biopsy.

X-ray examination is much more useful in the atrophic, fatty postmenopausal breast. It is less reliable in younger, premenopausal, glandular or dysplastic breasts. Radio-dense glandular tissue or dense mammary dysplasia may obscure small occult carcinomas. However, the large amount of fat in the postmenopausal breast acts as a natural contrast to remaining breast tissue and masses because of the differential absorption of the x-ray beam. A technique of low kilovoltage peak (KVP) and high milliamperes per second (MAS) is optimal due to this differential x-ray absorption of fat.

The examination is done by technicians trained in proper positioning and technique. Either special fine detail x-ray film or Xerox plates may be exposed for imaging. When film technique is used a special molybdenum target x-ray tube offers some advantages. An ordinary tungsten target x-ray tube or a molybdenum tube with added filtration may be used with Xerox plates. There is not total agreement among mammographers as to the optimal imaging system. However, the Xerox process has gained in popularity the last few years. At the Cancer Research Center, we are currently using the Xerox process and have found it satisfactory and reliable.

At least two views of each breast are made. One is made with the patient sitting and the exposure made in a cephalocaudad projection. The other routine projection is a lateral view, preferably with the patient recumbent. Special additional views in different projections or of the axillary tail of some breasts are obtained when deemed necessary.

Radiographic interpretation is not always easy and even some of the best quality images offer severe diagnostic challenges. Unfortunately, not all masses are imaged sufficiently for accurate interpretations. Not all carcinomas have the classical appearance or tell-tale calcification to be specifically diagnostic. Occasionally, a benign-appearing mass may be malignant. In spite of these occasional shortcomings, however, the procedure has proven to be of benefit in a large percentage of instances.

The protocol of our current study requires that each modality be interpreted initially without the results of any of the other modalities. Depending on the total findings, a biopsy or early recall (prior to annual recall) may be suggested. A final recommendation is not reached, however, without first considering all modalities of the project—the history, physical findings, thermogram and mammogram. Normal findings in all four tests result in a 12-month recall.

If a final recommendation of biopsy is made on a nonpalpable or palpable lesion, a word description, localization and a marked diagram are sent to the surgeon to help him excise the correct breast segment. With nonpalpable lesions, the surgeon's task is not easy. The lesion may change somewhat in location from its apparent position especially on the mammograms (made in upright and lateral recumbent positions with breast compression) when the patient assumes a supine position on the operating table. Also, some early intraductal cancers may not as yet have produced a mass even though they are evident on the mammograms as delicate punctate calcifications. It is suggested that the surgeon then obtain an x-ray of the specimen of excised breast tissue to be certain he has removed the suspicious cluster of calcification. This also will tell the pathologist where to obtain microscopic sections.

These four examinations are repeated annually for five years with a further five-year follow-up by a letter. All positive findings are reported to the private physician designated by the screenee. No treatment is carried out in the project. The total examination takes 1½ to 2 hours and is painless. It is at no cost to the participant since funds (National Cancer Institute) and voluntary contributions (American Cancer Society) are supporting the program. The project has received endorsement from the Boone County Medical Society.

We are attempting to apply research methods in diagnostics to the earlier diagnosis of breast cancer.[14] It is planned to screen about 5,000 women each year for two years and then to *discontinue* new appointments and devote the subsequent time to follow-up. It is too early to make any report other than the fact that we are screening about 25 to 30 women each day. With strong support from the Missouri Division of the American Cancer Society and its volunteers, we have a viable project and can expect to reach our projected goals. Response from both physicians and women in Missouri has been positive.

We will continue to report periodically to the physicians of Missouri as time passes and experience and volume increase.

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The 28th National Conference on Rural Health of the American Medical Association will be held on March 20-21, 1975 at Roanoke, Va. "New Approaches to Old Problems" will be the theme of the annual meeting for next year. Speakers and panelists will explore new needs and report on new developments in family practice physicians-residency programs, National Health Service Corps in the areas of family practice physicians, a service commitment related to medical education, rural development and health services, rural medical centers and hospitals, student projects; motivations for rural practice, rural health legislation, emergency medical services, consumer health education and community involvement in health.

CLIFFORD W. RICHTER, Ph.D., *Columbia*

Clinical Parameters of High Energy Linear Accelerators

In radiation therapy, it is necessary to develop new radiation sources having physical characteristics that allow the delivery of dosage tailored to the tumor of the patient undergoing treatment. It is extremely desirable to be able to treat close to the skin with electron beams which will spare underlying structures and still easily change the machine to a mode that will treat deep-seated tumors.

The Ellis Fischel Hospital has been engaged for the past two years in drawing up specifications for and purchasing such an accelerator. This accelerator is due to be operating for patient use in the late spring of 1976. When completed and installed, it will become one of seven linear accelerators of this energy in the Western hemisphere.

The advantages of the linear accelerator over other radiation sources are its larger field size, its high dose rate and its treatment with both electron and high energy photon beams. The larger field size provides a definite advantage in treating fields the size of those present in Hodgkin's disease. The linear accelerator allows treatment of one large field, rather than abutting two or more small fields. Areas of abutting fields may be overdosed or underdosed. The accelerator has variable collimators that adjust from a 0 x 0 to 40 x 40 cm field at 1 meter from the source. The treatment table will lower to treat a 50 cm x 50 cm field on a 25 cm thick patient. The dose rate of the linear accelerator should be in steps or continually variable. Dose rates of 400 rads per minute at 1 meter are optional. We have specified dose rates variable from 50 rads to 1,000 rads per minute at 1 meter. This allows using a high dose rate on patients who have problems holding still for long periods of time. In addition, high dose rates allow greater use of the machine in a shorter treatment period. This is a definite advantage over other types of high energy equipment. Patient movement is monitored by isovigilant lasers located in four positions in the treatment room. These lasers automatically interrupt patient treatment if the patient moves a predetermined amount. These lasers also aid in defining where the treatment beams will be aimed. The patient is observed on closed circuit television during treatment.

Electron beams allow treatment of superficial tumors. The nature of the electron beam allows, by controlling the energy, an exact penetrability in tissue and little radiation is given beyond a certain depth. This type of beam is required for extensive skin cancers, certain head and neck cancers and some breast cancers, postoperatively. This beam also allows radiation treatments to be given in cases in which a photon or x-ray beam cannot be used.

The linear accelerator delivers by a simple pushbutton nine electron energies ranging from 7 MeV to 40 MeV. This gives a variable penetrability from 2.5 cm for the 7 MeV up to approximately 15 cm for the 40 MeV electron, with almost no dose given after this depth.

High energy x-ray beams allow treatment of deep seated tumors. The point of maximum dose buildup is at 4 cm for the 25 MeV x-ray beam. This allows almost total "skin sparing." With high energy x-rays, it is possible to deliver significant doses of radiation into pelvic structures and to give only small skin doses. This high energy beam is expected to reduce the complications of radiation associated with the treatment of deep seated tumors.

"A welcomed addition in the battle against cancer" will be the high energy linear accelerator which is being purchased for Ellis Fischel State Cancer Hospital and is scheduled to be operating for patient use in 1976. This paper presents a comprehensive description of the advantages and uses of the accelerator as a new radiation source for treatment of patients. Dr. Richter is Chief, Department of Medical Physics at the Hospital. This investigation was supported by Clinical Cancer Training Grant #CA-08018 from the National Cancer Institute.

This accelerator is equipped with both 10 MeV and 25 MeV x-ray beams.

There are many other advantages that this machine offers, such as being fully rotational and treating in both the electron and photon mode during rotation or arc therapy. It has a small penumbra width and a high-energy specialized beam for the production of short-lived isotopes, plus many other technical specifications.

The linear accelerator offers an extremely easy set up for treatments of patients. All machine motions are controlled from a hand-held pendant to allow the technicians extreme flexibility and ease of machine control during patient set up. All set up motions of the linear accelerator are monitored as are patient treatment data. These data are fed into a system designed to verify that all set ups are correct before treatment can begin. At the end of the treatment, all treatment parameters are automatically recorded and printed out to become part of the patient treatment record.

Safety in use both to the operator and patient is a prime concern. There are 19 separate interlocks and any one can prevent or stop the machine's operation by giving a fault indication as to the source of trouble.

The linear accelerator does not make other modes of therapy inadequate or obsolete. Cobalt 60 will still be the treatment of choice for over half the cancers that are treated with radiation therapy. Cobalt 60 treatment may well be supplemented with high energy electron or photon beams during or toward the end of treatment in certain instances. The high energy linear accelerator is a welcomed addition in the battle against cancer.

Acute Luekemia

(Continued from page 684)

leukemia and other neoplasms in man are not as conclusive as they are for radiation. However, they are strongly presumptive, and great caution should be associated with the use of these drugs, especially in benign conditions.

Therefore, in certain circumstances, acute leukemia and, perhaps, other neoplasms may be diseases of medical progress. This is not to imply that chemotherapy and radiotherapy have not improved survival and relieved suffering in patients with malignant diseases. But, it may be that because of the prolonged survival of patients with advanced malignant disease induced by these modalities of treatment that patients now live long enough to sustain the complications of therapy.

Summary

Acute leukemia is not part of the recognized natural history of either multiple myeloma or Hodgkin's disease. Two patients are reported; one with myeloma and one with Hodgkin's disease. Each developed acute leukemia. These patients, as well as those in all other reported cases in which this association occurred, had been treated with chemotherapy or radiation therapy or both. Perhaps, the leukemogenic potential of radiation and the immunologic suppression induced by chemotherapy played an important role in the etiology of the acute leukemia.

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Ellis Fischel State Cancer Hospital
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OSCAR N. GUERRA, D.D.S., M.S.P.H., ***Columbia***

Prosthetic Management of Surgically Induced Defects of the Palate

The immediate advantages provided by specially designed obturators for the patient undergoing maxillary resection are discussed by the author in this article. He also cites the importance of close cooperation between the surgeon, dentist and patient in successful rehabilitation of the patient. Dr. Guerra is Chief, Department of Maxillofacial Prosthetics at Ellis Fischel State Cancer Hospital and the Cancer Research Center. This investigation was supported in part by General Research Support Grant #FR-05618 from the National Institutes of Health.

Malignant neoplasms which occur around the region of the nasal cavity and the paranasal structures often require surgical resection. The malignant neoplasms which occur regularly in this area are squamous cell carcinoma, adenocarcinoma (most arise from respiratory mucosa), metastatic carcinoma and melanoma.[1] The surgical procedure varies depending on the location and size of the tumor. Any opening between the oral cavity and the nasal cavity or the maxillary antrum, however, severely compromises mastication, speech and deglutition. Small defects of the maxilla can be repaired surgically, immediately or at a later date. Larger defects caused by surgical removal of neoplasms often require prosthetic replacement.[2]

Specially designed obturators provide several immediate advantages to the patient undergoing maxillary resection. A surgical obturator which is constructed prior to treatment and is inserted immediately after the resection serves as a matrix for the surgical dressing (Fig. 1). If the surgical dressing is disturbed or removed before the graft has healed adequately, there is a possibility that the skin graft will break away from the raw wound. The surgical obturator provides an optimal method of maintaining the dressing in place. This prosthesis also protects the wound from food debris. Because the obturator reduces the time that the nasogastric tube must remain in place, food can be taken by mouth soon after surgery. The prosthesis also supports the oral and facial structures in the normal positions by minimizing scar contracture. The possibility of postoperative hemorrhage is greatly reduced by maintaining pressure directly or indirectly on the split thickness skin graft. Psychological support also is provided to the patient's feeling of well-being by immediately providing facility in speech and deglutition. Not all of these functions will be realized in all obturators. The degree of success that a patient achieves in utilizing a surgical obturator depends on (1) the size and location of the surgical defect, (2) the presence or absence of teeth in strategic areas, (3) the degree of preoperative planning by the surgeon and the maxillofacial dentist and (4) the amount of involvement by the dentist in the patient's postoperative course.

After adequate healing has taken place, the surgical obturator no longer conforms to the remaining tissue. A temporary or short-term obturator (Fig. 2) is then utilized with adjustments for a period of time, which usually is six months or until complete healing has taken place.[3] During this time the obturator permits the patient to function properly but allows the surgical area to be adequately observed during postsurgical follow-ups. Artificial teeth should not be placed on the obturator until one is sure that the supporting structures are suf-

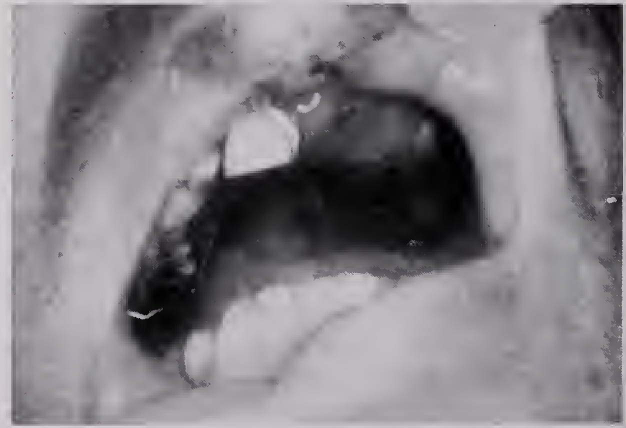

Fig. 1 A surgical obturator inserted immediately after the maxillary resection closes the opening between the oral cavity and the nasal cavity. This closure enables the patient to function earlier and aids in the retention of the surgical dressing.

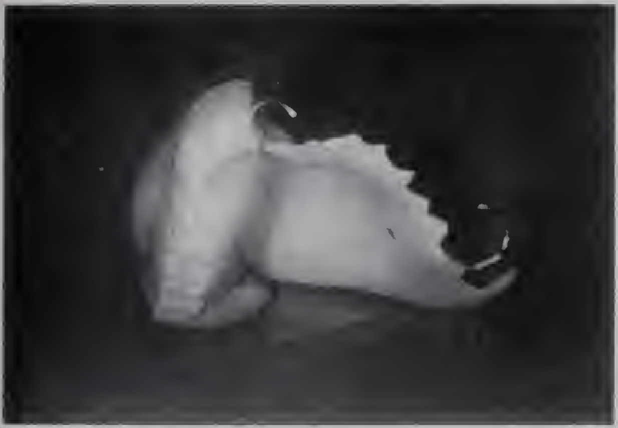

Fig. 2 A temporary obturator is constructed after sufficient healing has taken place to allow the tissues to withstand the stress of mastication.

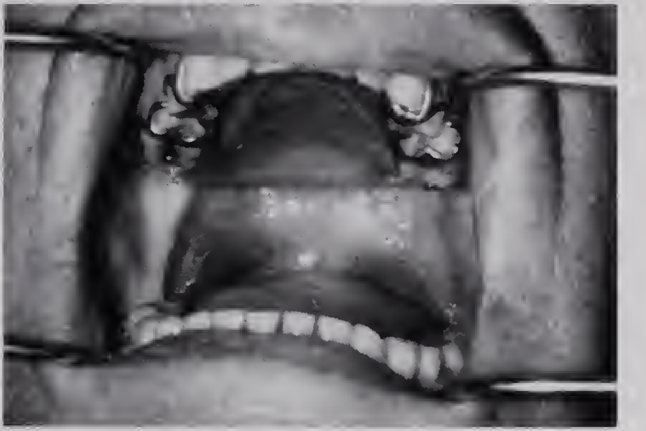

Fig. 3 This patient has a large maxillary defect which is effectively sealed by a long term obturator which utilizes a cast framework and semiprecision attachments.

ficiently healed to withstand masticatory stresses.

"The final or permanent obturator for the dentulous maxilla is designed according to the best principles of crown and bridge and partial denture construction (Fig. 3). That is to say, all abutment teeth are best crowned with a properly surveyed and executed gold or gold and porcelain veneer. Splinting of adjacent teeth is advisable in almost all cases. Multiple clasps, auxiliary rests and semiprecision or precision retentive means may be employed."[4] Very often, the obturator must extend into the defect in the form of a bulb. Many times this bulb is hollowed out prior to insertion because it is necessary that the prosthesis be as light as possible in order to maintain adequate retention.

Optimal utilization of intra-oral prostheses constructed to rehabilitate patients with maxillary defects requires that the patient maintain oral hygiene. As a general rule, the greater the number of teeth which can be retained, the better the results. For this reason, all teeth which are in need of dental restorations should be restored. Routine follow-up visits should be scheduled in order that any adjustments can be properly made.

Close cooperation between the surgeon, the dentist and the patient can result in successful rehabilitation of the patient. "Cure" must no longer be restricted to mean ridding the patient of his disease. We also must provide the means for that patient to return to his society.

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Continuing Education Coming Events

Dec. 12-14	**The Heart—1974: Current Topics of Cardiology** Continuing Medical Education, MU-KC School of Medicine Crown Center Hotel, Kansas City
Jan. 14-15	**Midwest Symposium on Bone** Continuing Medical Education M.U. Medical Center, Columbia
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President's Message

It is most difficult these days for me not to be old fashioned. At the risk of alienating some of my colleagues who have matured since the depression ended with the advent of World War II, I am going to state a few values that have served me well, but which now seem to be as dead as Marley's Ghost.

I was brought up to believe that the wealthy got that way through industry and thrift. True, there were occasional scalawags, but these always come to justice. It is difficult for me to believe any other way. It is difficult likewise, to find anyone below the age of 40 who really believes that a little extra work is, at best, anything but a nuisance and, at worse, an imposition. To them, being on a cash basis is of dubious virtue, and to forego buying something "I want" for the sake of staying on a cash basis instead of using credit is the height of the ridiculous.

The other day, I said I couldn't afford something (I think it was a $15 necktie). When the laughter died down, I tried to explain that while I am capable of paying for it, I can't afford it because no necktie would ever be worth $15 to me, and I can't afford $15 or 15¢ for something that, to me, would never be worth a third of the price. There are many things I can't afford. I can't afford to spend my time or my energies on projects that are unfulfilling.

James C. Cope, M.D.

I was brought up to believe such epigrams as "A penny saved is a penny earned" or "Waste not, want not" and to practice these precepts. When a bar of soap had been used until it was so thin it was in danger of breaking, my mother plastered it to a new bar and not a vestige of the old bar was wasted. The garbage which now goes down the disposal was "recycled" by the garbage man into pork chops and ham. Once, when I was about four years old, my grandmother reached into a box above her wood range and picked up a handful of salt. She used what she needed to season the soup and then placed the unused portion in my hand with instructions to put it on a large rock outside the kitchen door. "Nothing that any living thing can use should ever be wasted," she said. The next morning the salt was gone.

In spite of my wife's protests, the garage is full of the disposable items from the hospital. The plastic trays are just fine for starting tomatoes. The irrigation sets are good for watering house plants, small hypo syringes make good oilers for hard to reach spots and the scrub brushes find a thousand uses as do the disposable rubber gloves. Miss Hochuli, whom some of you know, could have run Boone County Hospital with the stuff that now goes out in the trash. I have yet to be convinced that these "disposables" have saved the patient one penny or have reduced the cost of care.

When I started my internship in Kansas City General Hospital in June of 1941, the

(Continued on next page)

Director, Dr. Drury Thorne said, "You may spend six hours a week outside the hospital, but only if your partner is taking call for you." Neither my intern partners then nor my contemporary colleagues now thought we were abused-nor do I believe I was harmed by the experience. (History records that the six-hour rule occasionally was seriously bent, if not sometimes broken!)

When I started to practice in 1949, I had enough money to last for six weeks. If, at the end of that time I wasn't breaking even, I would have been in serious trouble. I was plenty glad to answer the telephone at 2 AM or to receive a call from the Emergency Room. I was on call 24 hours a day, and the more calls the better. The fact that I was trying hard to please may have even made me a better doctor—at least, it didn't hurt. It was during this time of my life that I formed one of my basic rules. "When you start thinking that you are doing the patient a favor by seeing him instead of realizing that the patient is doing you a favor by requesting your services, it's time for you to take a vacation and restructure your thinking."

So, what then does all this catharsis avail?

I believe that careful buying and paying cash for the things that you must have will bring down prices.

I believe that conservative investing of saved money will bring interest rates down.

I believe that avoidance of waste will have the same beneficial effect as increased production.

I believe that neglect of these things has contributed immeasurably to our present difficulties.

I believe that the worst offender is a profligate Federal Government.

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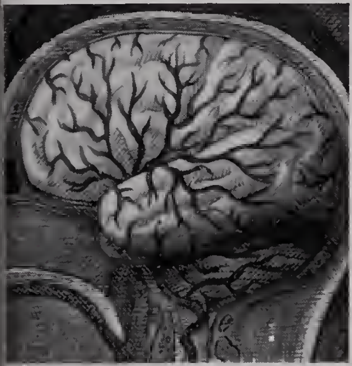

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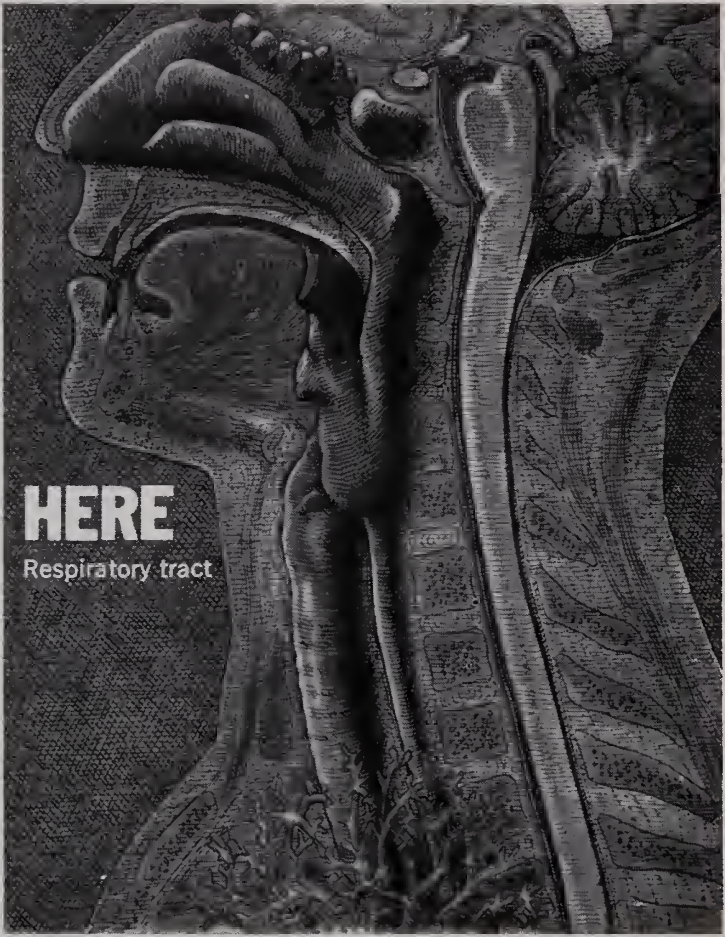

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The Role of the Detail Man

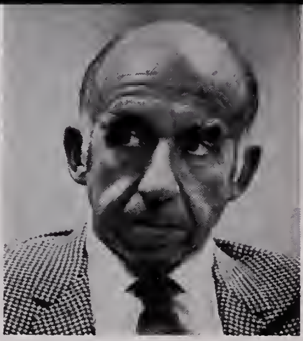
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community
Health and Preventive
Medicine, and Dingman
Professor of Cardiology
Northwestern University
Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center research people, and academic people have and that's in all likelih on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in thi

s He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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Woman's Auxiliary

50th Anniversary

December! It's a time of holidays and hectic happiness. Members of the Woman's Auxiliary to the Missouri State Medical Association can take a few minutes to make Christmas wishes for the organization.

The number one priority in Missouri is Auxiliary membership. The best gift of all would be 100% membership. This can be accomplished if every member of the Missouri State Medical Association will urge his wife to join.

Another great wish for the Auxiliary would be a more accurate image in some instances. Doctors' wives work hard in their communities, yet many citizens erroneously think of them as persons of leisure. In reality, doctors' wives should be considered first as resource persons in any community project.

Now, here are some Christmas gift suggestions! These unique gifts can cost from only $5 to $5,000.

1. *For your favorite doctor*—the one who took out your children's tonsils, who has everything and doesn't need another bottle of after-shave lotion. Send a donation to the Missouri State Medical Foundation in his name. You can see that this is a real triple-headed bargain. You further Missouri medicine, you please your doctor *and* you get a tax deduction!

Mrs. George J. Lytton
President

2. *For your Christmas cards*—Purchase one of the many beautiful designs available from the Auxiliary AMA-ERF chairman in your county. Once again, you will make $1 do the work of many.

3. *For your special lady*—See your local Auxiliary AMA-ERF chairman and select a stunning watch or jewelry. You will be amazed at the variety and beauty of the merchandise offered.

You will note that the above suggestions offer the ultimate in convenience and minimum shopping time. You also will note that you will be contributing to important, worthwhile causes.

We do hope that you have a happy holiday season. May your hearts be warmed by your contributions.

HAPPY HOLIDAYS! JOYOUS 1975!

County Society News

NINTH DISTRICT

COUNCILOR
CLAUDE W. COOPER, M.D., THAYER

Mid-Missouri County Medical Society

The Mid-Missouri County Medical Society met at Fort Leonard Wood on September 19, 1974.

Dr. Frank Elders reported on the survey regarding compulsory AMA membership which was sent to the councilor district members. He read his letter to Dr. Cooper, Councilor. The letter was sent to 47 members, and 40 members replied within two weeks (one member had retired, two had moved away and one was on vacation). In the replies, two members approved, one was noncommittal and 37 members expressed strong opposition. In a conversation with Dr. Elders, Dr. Cooper agreed to present the views of the members to the MSMA Council, which he did.

Election of officers was held at the meeting. Dr. B. J. Bass was elected President and Dr. Bernard Draper was elected Secretary-Treasurer. Delegates and Alternate Delegates to the MSMA were elected as follows: *Phelps County,* Earl E. Feind and Barbara E. Russell; *Laclede County,* R. W. Froelich and Howard V. W. Carrington; *Dent County,* B. J. Bass and Roy E. Mitchell; *Maries County,* Bernard Draper and Eugene F. White; *Pulaski County,* Clyde S. Miller and Barbara E. Russell; *Crawford County,* Frank A. Elders, Jr. and Albert R. Baumann; *Noncommitted,* James D. Butts and Ilse Heilbrunn.

It was moved by Dr. Elders and seconded by Dr. Butts that three new members be accepted into membership as recommended by the Membership Committee. The motion passed.

Bernard Draper, M.D., *Secretary*

TENTH DISTRICT

COUNCILOR
ENGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Mineral Area Medical Society

The Mineral Area Medical Society met in the Hoctor Building at the Farmington State Hospital at 7:30 PM on October 31.

The scientific program consisted of a discussion on "The Initial and Continuing Control of Juvenile-Onset Diabetes" by Robert Jackson, M.D. and Ronald James, M.D. of the University of Missouri School of Medicine in Columbia.

The business meeting was opened with a discussion of MSMA projects by Mr. Donald Wilson, Field Secretary for the Association. Following his presentation, the election of officers for 1975 was held.

Dr. Norman Farmer was reelected President, Dr. R. C. Hoye was elected Vice-President and Dr. C. W. Chastain was reelected Secretary-Treasurer.

On motion by Dr. Charles H. Appleberry, seconded by Dr. Chastain, the Society endorsed the establishment of a Regional Medical Library at the Farmington State Hospital in Farmington.

William Nicolay, M.D. of Fredericktown, who is a new physician in the area, was introduced to the members.

It was announced by Dr. Chastain, Secretary, that a Medical-Legal Banquet will be the next organized function of the Society.

Members present were Drs. Appleberry, Rivermines; William Nicolay, Fredericktown; and Alvan G. Karraker, Juan Cancelada, Robert C. Hoye, George B. Neukom, Chastain, Jay F. Tuttle and Norma D. Farmer, Farmington.

C. W. Chastain, M.D., *Secretary*

In Memoriam

Ben H. Brasher, M.D., Lexington, a graduate of Kansas University, 1933; member of Lafayette-Ray County Medical Society; age, 69; died Oct. 8, 1974.

Arthur E. Strauss, M.D., 6833 Waterman Blvd., St. Louis, a graduate of Harvard Medical School, 1917; member of St. Louis Medical Society; age, 84; died Oct. 9, 1974.

New Members

H. N. Analkat, M.D., 2639 Miami, St. Louis, has become a member of St. Louis Medical Society. Dr. Analkat is a native of India, received his preliminary education at Bahauddin College and his M.D. degree at M. P. Shah Medical College in 1970. He is an intern.

Howard J. Aylward, Jr., M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Aylward is a native of St. Louis, received his preliminary education at Boston College and his M.D. degree at Vanderbilt University in 1970. He specializes in internal medicine.

Larry E. Benson, M.D., 2700 Hospital Dr., Kansas City, has become a member of Clay County Medical Society. Dr. Benson is a native of Kansas City, received his preliminary education at William Jewell College and his M.D. degree at the University of Kansas in 1966. He specializes in nephrology and internal medicine.

Sylvia S. Babu, M.D., 825 Euclid, Kansas City, has become a member of Jackson County Medical Society. Dr. Babu is a native of India, received her preliminary education at Christian Medical College and her M.D. degree at Christian Medical College in 1964. She specializes in pediatrics.

M. Scott Beall, M.D., 6700 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. Beall is a native of St. Louis, received his preliminary education at the University of Michigan and his M.D. degree at the University of Missouri in 1969. He specializes in orthopedic surgery.

Robert D. Conn, M.D., 4420 Wornall, Kansas City, has become a member of Jackson County Medical Society. Dr. Conn is a native of Great Bend, Kan., received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1960. He specializes in internal medicine.

Richard B. Curnow, M.D., Westowne Offices, Liberty, has become a member of Clay County Medical Society. Dr. Curnow is a native of Whittier, Calif., received his preliminary education at Central Methodist College and his M.D. degree at the University of Missouri in 1967. He specializes in orthopedic surgery.

Manju Devgan, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Devgan is a native of India, received her preliminary education at Senior Cambridge and her M.D. degree at Makerere University in 1966. She specializes in pathology.

Richard T. Falter, M.D., 2700 Hospital Dr., Kansas City, has become a member of Clay County Medical Society. Dr. Falter is a native of Pennsylvania, received his preliminary education at Kansas State College and his M.D. degree at the University of Kansas in 1967. He specializes in ophthalmology.

James M. Gordon, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Gordon is a native of Minnesota, received his preliminary education at the University of Minnesota and his M.D. degree at the University of Minnesota in 1966. He specializes in ophthalmology.

Sam D. Hoeper, Jr., M.D., 24th and Cherry, Kansas City, has become a member of Jackson County Medical Society. Dr. Hoeper is a native of Kansas City, received his preliminary education at Central Missouri State University and his M.D. degree at Creighton University in 1973. He specializes in internal medicine.

Demetrius Jarosewycz, M.D., St. Louis VA Hospital, St. Louis, has become a member of St. Louis Medical Society. Dr. Jarosewycz is a native of Poland, received his preliminary education at Stanislaviv and his M.D. degree at Jana Kazimierza University in 1943. He specializes in psychiatry.

Michael F. Kaplan, M.D., 1409 Overhill Rd., Columbia, has become a member of Boone County Medical Society. Dr. Kaplan is a native of Detroit, Mich., received his preliminary education at the University of Louisville and his M.D. degree at the University of Louisville in 1964. He specializes in plastic and reconstructive surgery.

Frank A. Krewet, III, M.D., 1700 S. Second, has become a member of St. Louis County Medical Society. Dr. Krewet is a native of St. Louis, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1967. He specializes in internal medicine.

Claude K. Leeper, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Leeper is a native of McMinnville, Tenn., received his preliminary education at Southeast Missouri State Teachers College and his M.D. degree at the University of Missouri in 1946. He specializes in pathology.

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were *Dr. James C. Cope,* President of the Missouri State Medical Assocation, and *Dr. Fred D. Fowler,* President of Jackson County Medical Society. *Dr. Ward Darley,* President Emeritus of the University of Colorado and former Dean of the University of Colorado School of Medicine, was the dedicatory address speaker. About 1,000 persons toured the new building in small groups following the ceremony.

WASHINGTON UNIVERSITY

President Gerald R. Ford has reappointed an otolaryngologist and appointed a radiologist from Washington University School of Medicine to the National Cancer Advisory Board.

Joseph H. Ogura, M.D., Lindburg Professor and head of the Department of Otolaryngology, has been on the board since 1972 when he was named to complete the term of the late *Wendell C. Scott,* M.D., professor of clinical radiology.

William E. Powers, M.D., professor of radiology and director of the Division of Radiation Oncology of the Mallinckrodt Institute of Radiology, is the new appointee to the highly respected 18-member group.

The appointees, who are named for six-year terms, advise and assist the director of the National Cancer Institute in matters pertaining to the National Cancer Program. They also review ongoing cancer research programs and the National Cancer Institute's budget, and make recommendations to the President's Cancer Panel and to the NCI director.

Two Washington University physicians have been elected to the top positions of the American boards which certify specialists in their fields. *Sidney Goldring,* M.D., professor of neurological surgery, is chairman of the American Board of Neurological Surgery (ABNS). *William M. Landau,* M.D., professor of neurology, is president of the American Board of Psychiatry and Neurology (ABPN).

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

B. L. Myers, M.D. of Kansas City discussed "What Shall We Teach Regarding Chronic Appendicitis?" The last two decades have been marked by much contention concerning chronic appendicitis.

In 1932 in a well written paper, Watkins called attention to 662 papers on the subject that had been published up to that time. Urban Maes *et al,* who recently (1934) have written striking articles on appendicitis both during childhood and in persons of advanced years, are now reminding us of the words of Bastianelli who said, "When physicians are discussing whether or not the case is appendicitis, it is. When they are inclined to admit the possibility of appendicitis without being perfectly sure of it, it not only is but it is about to perforate. When the diagnosis is sure, there is already perforation with more or less circumscribed peritonitis." Miller of Pennsylvania University, who in 1932 wrote convincingly regarding appendiceal conditions, said, "I believe the present outcry in the profession against the removal of the so-called chronic appendix is a step backwards." Lahey (1932) suggests that we are suffering from being conscience-minded because we have removed appendices without fruitage and are now swinging to the other extreme and leaving appendices in that are endangering the patients."

TWENTY-FIVE YEARS AGO

Color television will be shown for the first time in Missouri at the 100th Anniversary Session of the Missouri State Medical Association to be held at the Jefferson Hotel in St. Louis on March 26-29, 1950. Surgical procedures and medical diagnoses and treatment will be transmitted from the St. Louis City Hospital to the Gold Room of the Jefferson Hotel.

Color television makes it possible for the first time for members attending the session to view the actual operations and medical work instead of hearing oral reports. The committee in charge of programs to be presented on television acts as a subcommittee of the Committee on Scientific Work. Members are Cyril Costello, M.D., chairman, Raymond O. Muether, M.D., Paul O. Hagemann, M.D. and Leo V. Millegan, M.D., all of St. Louis.

The Clay County Medical Society held its second clinical conference at the Elms Hotel in Excelsior Springs on November 3. The meeting began with a round table luncheon at 12:15 PM at which "Uses of Intravenous Procaine" was discussed by Dr. Milton C. Peterson of Kansas City and a discussion on "Short Anesthetics for Office Use" was presented by Dr. Louis Porter of Kansas City. Dr. J. E. Baird of Excelsior Springs presided.

The Department of the Army is urgently in need of medical officers to serve in a civilian capacity with the occupation forces in Japan. These positions, which involve the performance of the various duties of a general practitioner on an Army Hospital Staff, offer an opportunity for broad experience. The salary for these positions is $6,235.20 per year plus 10% post differential with quarters provided at no cost to the employee.

TEN YEARS AGO

Dr. William Donegan joined the staff of the Ellis Fischel State Cancer Hospital as assistant surgeon on July 1, 1964. Dr. Donegan received his B.A. degree magna cum laude from Yale in 1955 and his M.D. degree from Yale in 1959. He is a member of Phi Beta Kappa. He received his postgraduate surgical training at Barnes Hospital and at the Ellis Fischel State Cancer Hospital. He will be working on the biostatistics of mammary cancer and the prevention of recurrent cancer on the chest wall after radical mastectomy. The senior resident surgeons at the Ellis Fischel Hospital for the coming year will be Drs. Ronald Turner and Andrew Walker. Dr. Turner graduated from St. Louis University in 1959 and Dr. Walker graduated from Vanderbilt University in 1960.

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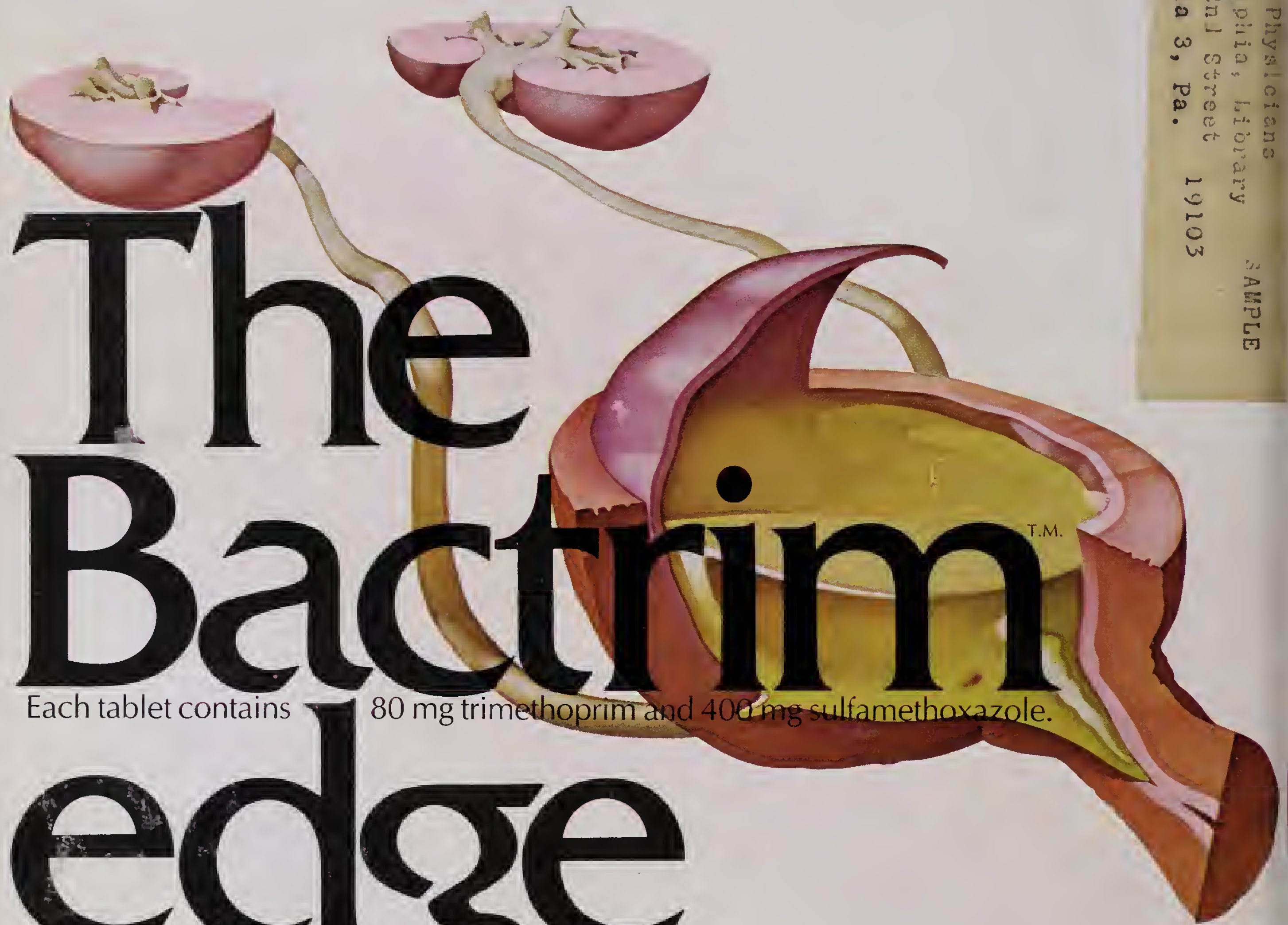

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